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JOURNAL OF THE
KENTUCKY MEDICAL
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1996 KMA
Legislative Handbook
Enclosed



JANUARY 1996

JOSEPH SMITH, M.D.

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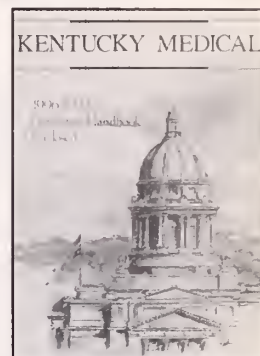


KENTUCKY MEDICAL INSURANCE COMPANY

JOURNAL OF THE
KENTUCKY MEDICAL
ASSOCIATION

VOLUME 94, NUMBER 1

JANUARY 1996



COVER: Kentucky's Capital, magnificent in total effect yet plain and classic in its lines, is one of the handsomest statehouses in America. Much French influence is found in the building. The rotundo and interior of the dome, and the lantern and dome exterior, were copied from the Hotel des Invalides over Napoleon's tomb in Paris. Louisville artist Lee Wade has vividly captured the beauty of the Capitol's dome for this month's cover as well as the cover of the 1996 Legislative Handbook, which is enclosed with this issue.

| | | |
|--------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
| SCIENTIFIC | Diaphragmatic Paralysis Following Scalenotomy for Thoracic Outlet Syndrome <i>Michael Heine, MD; Thomas M. Roy, MD</i> | 13 |
| | Use of Laparoscopy in the Treatment of Acute and Chronic Right Lower Quadrant Pain <i>F. Andrew Morfesis, MD, Fazal Ahmad, MD</i> | 16 |
| EDITORIAL | Autonomy <i>Daniel W. Varga, MD</i> | 23 |
| ASSOCIATION | <i>Monitoring Medicine</i> Goodin Elected to AMA Council on CME Kentucky Statewide CATO Society Meeting News | 7 27 31 32 |
| DEPARTMENTS | President's Page Advertisers' Guide Alliance Page Classifieds Continuing Education Calendar Information for Authors Letters to the Editor | 5 38 25 37 29 21 27 |

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Who, What, Where, When, and How?



Wally O. Montgomery, MD

A fairy tale that I read to my children and now read to my grandchildren tells of a little red hen. She was industrious and made sure that things were accomplished. She found a grain of wheat, but could not get help from her friends in grinding the wheat into flour, making the flour into bread, or baking the bread. Only when the loaf of freshly baked bread came out of the oven with its aroma did the "friends" show up wanting a piece of the action.

Who is the little red hen as related to KMA? I believe this is the 10% of members on the local, state, and national level who take part in leadership, committees, and board activities. The KMA has tried very diligently and has conducted prelegislative conferences in all 15 district trustee areas throughout the state. Although many were well attended, fewer than 10% of the physician members of KMA showed up.

What are you trying to learn about this legislative year of 1996? How much do you remember about House Bill 250 which passed in 1994 and included the provider tax? Many pre-filed bills have been introduced. Some have similar negative provisions.

Where is health reform legislation going in Kentucky? Many

of our "friends" in the Kentucky General Assembly were in Frankfort in past sessions without speaking up for physicians at all. Many others are still wanting to "sock it to us."

When will the legislative body and key government officials listen in Frankfort? All of us in leadership have talked to representatives and senators who have "crossed their hearts" and said that not one physician in their district spoke against the reforms passed in House Bill 250. Many of these legislators represent districts which have a large physician contingency.

How are you planning to harvest what you have planted? Many of us will find the loaf reaped to be very meager.

With this issue of the *Journal of the KMA* we present our legislative plans and background material for the 1996 session. Read it and become involved. It will take the diligent work of each physician of Kentucky to make a difference if we really want positive legislation to come out this session.

Wally O. Montgomery, MD
Chairman, State Legislative
Committee

"It will take the diligent work of each physician of Kentucky to make a difference if we really want positive legislation to come out this session."



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MONITORING MEDICINE

1996 KENTUCKY GENERAL ASSEMBLY KMA PLAN OF ACTION

This issue of the *Journal* presents information to assist you in contacts with elected Representatives and Senators. Due to several suggestions the format of the *Legislative Handbook* was changed this year to a pocket-size edition. We hope you find the edition more convenient and easier to use.

The following legislative plan of action was adopted by the KMA Board of Trustees based on KMA House of Delegates policy and previous positions by the Board of Trustees.

The KMA House of Delegates established the provider tax as the major priority for 1996. In addition, the House has reaffirmed tort reform as a major and primary objective of KMA's legislative program. The DOP, free medical records, Medicaid reimbursement, and practice parameters have all created concerns within the medical community.

The goals are broken down into two categories:

I. Primary — Definitive legislation will be introduced to meet House of Delegates objectives. Full pressure will be brought to bear to meet these objectives which will stand as our highest priority. Both members and legislators should easily identify with these goals as KMA's primary objectives.

II. Secondary — Legislation will be introduced to repeal, alter, or maintain present legislation and will be lobbied extensively.

PRIMARY GOALS

1. REPEAL THE PHYSICIAN COMPONENT OF THE PROVIDER TAX

- a. Allen Maricle (R) Bullitt County — Prefiled bill calls for repeal on all providers.
- b. Tim Shaughnessy (D) Jefferson County — Prefiled bill calls for repeal of the physician component.
- c. Tax Reform Study Commission — Recommends repeal of the physician component.
- d. Governor-elect Patton endorsed repeal of the physician component of the tax.
- e. James Crase, MD, (R) Somerset has prefiled BR 140 which calls for repeal of the provider tax.

2. TORT REFORM

Legislation will be introduced to amend Section 54 of the Kentucky Constitution to permit the KGA to cap noneconomic damages.

SECONDARY GOALS

1. REPEAL THE DISCOUNT OPTION PROGRAM

Tim Shaughnessy (D) and James Crase, MD (R), have both filed bills to repeal the DOP.

2. **FREE MEDICAL RECORDS**

Legislation will be introduced to permit providers to charge reasonable fees to provide copies of medical records.

3. **PRACTICE PARAMETERS**

Legislation will be proposed to correct present discrepancies or deficiencies in the provisions in HB 250 relating to practice parameters and to clarify their purpose and future use and implementation. James Crase,

MD, (R), Somerset, has prefiled legislation altering present format and establishment of practice parameters.

4. KMA supports retention of the Any Willing Provider provision as presently embodied in HB 250.

In addition, KMA will continue to work with the Administration and the Kentucky General Assembly seeking fair and equitable reimbursement for services rendered to Medicaid patients.

While KMA is on the offensive, it is fairly common to be faced with bills so onerous that defeating such legislation becomes a major priority. We can expect a host of bills coming from nonphysician practitioners, insurance companies, state government, and others that will require considerable attention. In addition, we are usually active in various safety, health, and insurance legislation which specifically affects patient care and public health concerns.

KMA

THERE'S A DOCTOR IN THE HOUSE . . . AND SENATE . . . AND EXECUTIVE BRANCH



**Representative
Bob M. DeWeese, MD**



**Representative
Ernest L. Fletcher, MD**



**Senator
Nick Kafoglis, MD**



**Senator
James D. Crase, MD**



Lt Governor Steve Henry, MD

THE LAWMAKING PROCESS

NEW laws aren't born overnight. First, the necessity or idea for a law must be established. Once an idea has been formulated, it is then drafted into bill form. Bill drafts come from any number of sources, but only a legislator can sponsor a bill and file it for consideration by the full assembly.

Bills can be introduced in one house or in both simultaneously — except for appropriations bills, which must originate in the House. But even identical bills must travel through each chamber.

Once introduced, a bill is read by title and number and referred to the committee having jurisdiction over the subject. The committee discusses the bill and makes a recommendation. Some pieces of legislation "die" in committee and never reach the floor. But if the bill is reported from the committee, it is put on the calendar for reading — three times, once per day. After it is read for the third time, the bill is voted on. A bill that receives a majority of the votes cast (with at least two-fifths of the membership present) is

passed on to the other chamber, where it undergoes the same procedure.

There are four types of legislation that require more than a simple majority for passage. Appropriations bills, the call for a constitutional convention and emergency bills (those which take effect immediately) require a favorable vote of the majority of all elected members. This is called a constitutional majority. Amendments to the state constitution must receive a favorable nod from three-fifths of the membership.

Once approved by both chambers, the bill has one more hurdle to overcome. It must be acted upon by the governor. The governor has three options: to sign the bill into law, veto the bill, or allow it to become law without his signature.

A vetoed bill can be sent back to the Legislature (first to the chamber where it originated) and the veto can be overridden by a constitutional majority.

Most legislation becomes law 90 days after the General Assembly adjourns.

A PRESCRIPTION FOR RESULTS IN THE LAWMAKING PROCESS

DO know the proper way to address a member of the legislature. In written correspondence, members of the House and Senate should be referred to as The Honorable John Smith and the letter should begin either Dear Senator Smith or Dear Representative Smith, whichever the case may be.

Don't expect results from form letters. This is the least personal, least effective way to communicate with an elected official. Most mailings of this type are filed away — usually in the trash.

Do ask for an appointment when you want a personal visit. Most members of the Kentucky General Assembly try to balance their time. They are more than willing to meet with constituents, but appreciate the courtesy of scheduling an appointment in advance.

Don't overstay your welcome. If you say you need 15 minutes, then speak your piece, check the clock and be on your way. Meetings of a complicated nature often require more time. Should this be the case, then make sure the legislator knows before the meeting starts, not after.

Do get straight to the point of the meeting. State your case

clearly and concisely, and be prepared to respond to any questions the legislator may have.

Don't bring volumes of written material with you. Unless the subject is extremely complex, a brief written summary, folder or fact sheet is preferable and more likely to be read.

Do know your subject matter inside out. If you are going to be a spokesperson for an issue or a cause, then you should be prepared to not only define it, but explain and defend it as well.

Don't be the source of inaccurate or misleading information. There is no substitute for truthfulness and candor in dealing with elected officials. Most of them abide by the old maxim, "Lie to me once, shame on you; lie to me twice, shame on me."

Do volunteer to provide additional data about the subject matter. When your cause or issue comes up, you want the legislator to think of you. Legislators want to be well-versed on all sides of your issue. The opportunity to provide continuing support material is not only in your best interest, but their best interest as well.

DID YOU KNOW . . . ?

Kentucky is a Commonwealth

The two designations "commonwealth" and "state" were synonymous when Kentucky joined the Union in 1792. Of the four commonwealths in the United States, Massachusetts, Pennsylvania and Virginia were originally British colonies. Kentucky was once a part of Virginia, and at the time of their separation it chose to call itself the Commonwealth of Kentucky.

Kentucky's Capitol

Kentucky's Capitol, surrounded by 34 acres of landscaped grounds — flower gardens, neatly trimmed shrubs and tree-lined sidewalks — was officially dedicated on June 1, 1910, and is still one of the most handsome statehouses in America.

Government

Kentucky's Constitution provides for three branches of state government — the legislative, to enact laws; the judicial, to interpret them; and the executive, to enforce them.

Offices of the executive, judicial and legislative branches of state government are housed in Kentucky's Capitol. The building is open every day, with free guided tours from 8 AM to 4:30 PM, Monday through Friday, and 8:30 AM to 4:00 PM on Saturdays, 1 PM to 4:30 PM Sundays, and 8 AM to 4:30 PM on most holidays. The tours visit the State Reception Room, the Supreme Court, the Senate and the House of Representatives.

Executive Branch

The governor is chief executive of the Commonwealth. He is elected for a four-year term, together with the lieutenant governor, secretary of state, attorney general, state treasurer, commissioner of agriculture, superintendent of public instruction, auditor of public accounts and the three members of the railroad commission.

The executive branch is divided into cabinets, each of which is headed by an appointed official called a secretary. The secretaries form the governor's cabinet and advise the chief executive upon many of his decisions concerning the administration of state government.

In addition, the executive branch consists of various independent agencies and regulatory commissions carrying out particular functions by law. Enforcement of the law not only involves insisting the law is obeyed, but also consists of many duties necessary in carrying out the law's provisions — most of which involve services to citizens of the Commonwealth.

Judicial Branch

Courts of the state interpret the laws, settle controversies between individuals and apply criminal sanctions. Kentucky greatly altered its court system when voters approved the Judicial Article in 1975 amending the state constitution. Part of the amendment took effect in January, 1976; other sections went into effect in January, 1978.

The new court system is based on a four-tiered structure of district courts, circuit courts, a 14-member Court of Appeals, and a seven-member Supreme Court.

District courts are courts of limited jurisdiction and serve judicial districts of one or more counties. Circuit courts have original and appellate jurisdiction as may be provided by law.

The Court of Appeals is divided into separate panels which have appellate jurisdiction. In addition, it may be authorized by the Supreme Court to review administrative agency decisions.

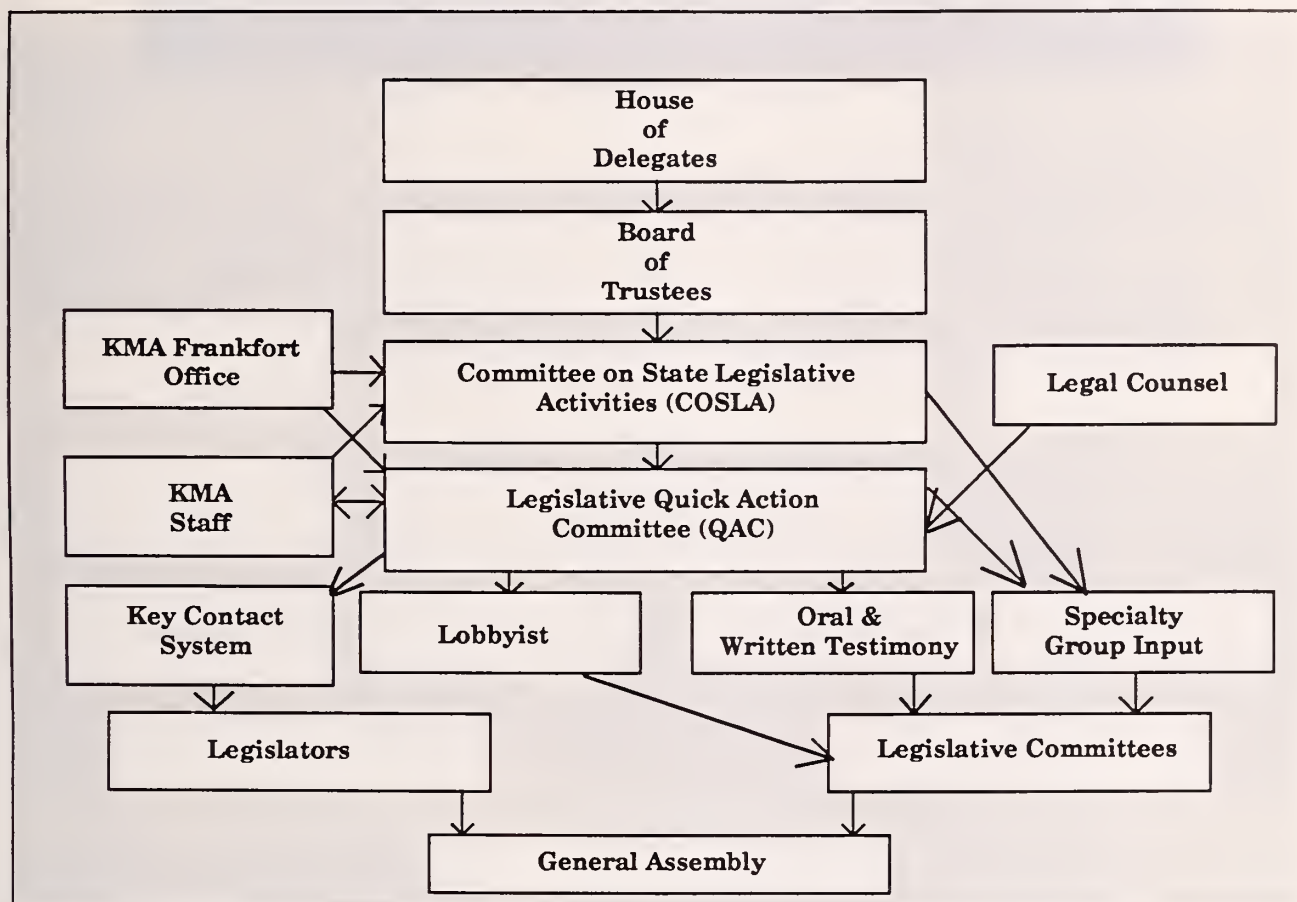
The Supreme Court hears lower-court appeals and assumes budgetary and administrative responsibility for the entire system.

Legislative Branch

Kentucky's General Assembly has two chambers — the Senate and the House of Representatives. One hundred representatives are chosen for two-year terms; 38 senators are elected for four-year terms. Every two years, all the representatives and one-half of the senators are elected. The General Assembly meets in regular session in January of even-numbered years. Regular sessions are limited to 60 legislative days. The governor may call the legislators into special session to consider matters specified by him. The General Assembly has the power to enact all laws — subject to the constitutional limitations. Proposed laws may be introduced in either chamber, but the House of Representatives must originate revenue-raising measures.

During the 59-day period, well over 1500 pieces of legislation will be considered, of which approximately 10% will be health related.

HOW KMA MONITORS AND REACTS TO PENDING LEGISLATION



The 1996 session of the Kentucky General Assembly convened on Tuesday, January 2, for 60 legislative days. KMA's role in the legislative process is to inform and advise legislators of the effect proposed health legislation will have on patients and the medical profession.

This process begins with the House of Delegates which establishes policy and sets priorities and the Association position on anticipated legislation.

The Board of Trustees establishes guidelines for the implementation of House policy.

The 1996 Legislative Quick Action Committee (QAC) is responsible for the day to day developments in the procedures of the General Assembly, and is comprised of the President, President-Elect, Chair of the Board, Secretary-Treasurer, Chair of the Committee on State Legislative Activities (COSLA), and KMA Past President. The QAC meets weekly during the session to monitor the current status of all bills, direct lobbying activities and arrange for presentation of testimony when needed. The COSLA seeks advice regularly from individuals and specialty groups on legislation because of the numerous amendments usually added to a bill during

the course of the session.

The Legislative Committee reviews proposed and prefiled legislation, prepares recommendations for addressing pending legislation and recommends procedures to carry out House directives on associational policies.

The Frankfort office of the KMA is maintained during the General Assembly by a lobbyist and an assistant. All legislation is reviewed for its possible impact on the Association and referred to the Legislative Committee, Board of Trustees and Quick Action Committee if indicated.

The key contact system provides one to one contact, physician to legislator, as a means of disseminating associational positions on particular legislation. This system has proved to be one of the most effective ways of communicating the Association's position on key legislation. KMA monitors approximately 200 different legislative proposals during a session.

The process of a bill becoming law, even without numerous amendments and referrals back to committee for reconsideration takes approximately 30 steps. And at any one step it may be delayed, amended or killed.

TIMES HAVE CHANGED . . .

. . . The disability insurance business has changed dramatically. Some companies have moved to more restrictive policies, others have simply quit writing traditional own-occupation/specialty coverage. The KMA disability plan underwritten by Commercial Life (a UNUM Company) *continues* to offer KMA members these important features.

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Diaphragmatic Paralysis Following Scalenotomy for Thoracic Outlet Syndrome

Michael Heine, MD; Thomas M. Roy, MD

Potential phrenic nerve injury that results in diaphragmatic dysfunction and respiratory insufficiency has important implications for the anesthesiologist who must insure adequate ventilation and gas exchange. A variety of traumatic injuries as well as some surgical manipulations have been identified with an increased frequency of diaphragmatic paralysis. We have observed the occurrence of this sequela after scalenotomy for thoracic outlet obstruction, a previously unreported association.

Iatrogenic phrenic nerve injuries are largely confined to the population that requires cardiac surgery.^{1,2} Because the phrenic nerves lie within the fibrous pericardium, hypothermic insult may result from the use of topical cold cardioplegia.² Physical injury to the phrenic nerves, secondary to compression or stretching, may also occur during exposure of the heart or with dissection of the internal mammary artery for coronary grafting.^{3,4}

Diaphragmatic dysfunction from injury to the upper phrenic nerve has been reported with deep vein cannulation⁵ illustrating that respiratory embarrassment can occur if the phrenic nerve is insulted at any point along its descent from the phrenic nerve nuclei.

We report a patient who experienced diaphragmatic paralysis from phrenic nerve injury after undergoing a scalenotomy intended to relieve neurovascular compromise at the thoracic outlet. To our knowledge this association has not been previously described in the literature, but has significance for the anesthesiologist who must wean ventilator support and direct measures to avoid postoperative pulmonary complications.

Case Report

The patient, a 45-year-old male, presented to the

Emergency Department with the chief complaint of shortness of breath. According to the patient, the dyspnea began 3 days earlier and was most pronounced when he would lie in the supine position or try to eat. He denied fever, cough, chest pain, or hemoptysis. Four days earlier, he had a right scalenotomy to relieve arm pain and numbness that was attributed to thoracic outlet obstruction.

The patient was dyspneic in the seated position with a respiratory rate of 26 breaths per minute. His heart rate and blood pressure were normal. A clean surgical scar was present superior to the right scapula extending up to the lateral cervical area. Breath sounds were decreased in the right hemithorax. The lower right posterior thorax was dull to percussion with absent tactile fremitus. No adventitious breath sounds were present. The remainder of his examination was unremarkable.

Upright PA chest radiograph was interpreted as showing a markedly elevated right diaphragm as compared to a recent preoperative chest film. A right lateral decubitus film was normal. Right phrenic nerve palsy with right diaphragmatic paralysis was confirmed by fluoroscopic evaluation.

Although the patient was dyspneic and tachypneic, his gas exchange without supplemental oxygen was satisfactory. Arterial blood gas analysis measured the PaO₂ at 71 torr, the PaCO₂ at 41 torr, and the pH at 7.41.

The patient was informed about the etiology of his dyspnea and was satisfied with follow-up in 24 hours with his surgeon. He was allowed to return home with instructions on optimal positioning to minimize his work of breathing.

Three months later, the patient was readmitted for a left scalenotomy for relief of left thoracic outlet obstruction. At that juncture, the patient's

Dr Heine is an Assistant Professor in the Division of Anesthesiology, University of Louisville School of Medicine, Louisville, KY, and Dr Roy is a Professor in the Division of Pulmonary Medicine, James H. Quillen College of Medicine, East Tennessee State University, Johnson City, TN.

Diaphragmatic Paralysis

respiratory complaints were minimal but his chest radiograph continued to document elevation of the right diaphragm.

Discussion

Unilateral diaphragmatic paralysis rarely causes severe respiratory compromise and its presence is often initially suggested only by the patient's chest radiograph. The sparsity of respiratory symptoms is due to successful recruitment of intercostal and abdominal muscles.⁶ Reduced exercise tolerance with dyspnea is found in about 24% of subjects with unilateral diaphragmatic paralysis.⁷ Mild orthopnea is a frequent complaint, but is less severe than in patients with bilateral paralysis. Tachypnea is occasionally reported.³

Physical signs are usually nonspecific. Paradoxical motion of the paralyzed diaphragm may be suggested by percussion of the thorax. Asymmetric motion of the abdominal wall in the supine position is often observed. There may be an associated reduction in breath sounds at the lung base on the affected side.⁷

Once diaphragmatic paralysis is suggested by the finding of an elevated hemidiaphragm on radiographic or physical examination, the cause can usually be determined in 40% of patients at the initial diagnostic evaluation. These investigations usually reveal the cause to be infectious, neuromuscular, traumatic, iatrogenic, or neoplastic.

In a study of 105 patients with an identifiable cause of unilateral paralysis, one-third had a history of thoracic or neck operations resulting in intentional or accidental phrenic nerve injury. Another third had phrenic nerve compression from bronchogenic carcinoma. The remaining one-third of patients had paralysis related to trauma, infection, or neurological disease.⁸ Clearly the anesthesiologist will be in a position to care for the majority of these patients at some stage of their treatment.

Traditionally percussion of the chest wall has been used to determine the position and range of movement of the diaphragm. The dome of the diaphragm ranges from 10 to 15 cm from the chest wall and moves more than the periphery of the diaphragm. Clinical interest is in regard to movement of the dome of the diaphragm. Measurement of peripheral diaphragmatic excursion is an imprecise estimate of actual diaphragmatic function. In fact, clinical measurements of diaphragmatic movement show limited value in de-

termining the diagnosis of physiologic impairment.⁹

Although the chest roentgenogram is often the first clue to diaphragmatic paralysis, one retrospective study suggests that it is neither sensitive nor specific for determining diaphragmatic dysfunction.³ Other indicators of diaphragmatic dysfunction should be employed.

Pulmonary function tests in diaphragmatic paralysis are consistent with a restrictive defect with reduced lung volumes, normal flow rates, and a relative increase in residual volume. Unlike patients with global respiratory muscle weakness, the expiratory reserve volume is relatively preserved.⁷

The simplest test in screening for diaphragmatic impairment is to measure the erect and supine vital capacity.⁶ In the erect position, vital capacity is well preserved because gravitational force improves the mechanical advantage of the accessory muscles of respiration. In the supine position, the abdominal contents encroach into the thorax resulting in reduced vital capacity with subsequent increased work of breathing.⁶ With unilateral diaphragmatic paralysis, the VC of seated patients is reduced to approximately 75% of predicted and an additional decline of 10% to 20% occurs when the patient lies flat.⁹

Fluoroscopy is a common method of assessing diaphragmatic function. It is more sensitive in the diagnosis of unilateral diaphragmatic paralysis where paradoxical motion of one complete hemidiaphragm is seen during the "sniff test." Fluoroscopy may reveal impaired descent on the affected side during inspiration, but typically an upward shift of that diaphragm during a sniff. Paradoxical motion should be at least 2 cm for a confident diagnosis of paralysis.⁷

Maximal inspiratory and expiratory pressure measurements can be used as indicators of global inspiratory and expiratory muscle strength.⁶ These indices are easily measured at the mouth or endotracheal tube using a closed-ended, large-bore tube with a pressure gauge.³ PImax (maximal static inspiratory pressure) is the maximum pressure achieved from residual volume, and PEmax (maximal static expiratory pressure) is the maximum pressure generated from total lung capacity.

Diaphragmatic dysfunction results in low maximal inspiratory pressures (PImax) to 43% of predicted.³ PEmax is generally not affected by diaphragmatic dysfunction and has been reported normal in all patients in one study.⁴

A transdiaphragmatic pressure measurement

could provide a quantitative index of diaphragmatic contractility,⁶ but the tension developed by the diaphragm cannot be measured directly. Phrenic nerve stimulation with diaphragmatic EMG and phrenic nerve conduction times may be useful adjuvants in locating the site and nature of the lesion contributing to dysfunction.⁷ This type of testing is cumbersome and uncomfortable.

Investigation of diaphragmatic function in cases of suspected paralysis is usually restricted to measurements of lung volumes and to the visualization of diaphragmatic movement by fluoroscopy. Methods for measuring phrenic nerve conduction, based on recording the diaphragmatic muscle action potential either with esophageal electrodes or surface electrodes over the lateral chest wall have not found general application. Thus in clinical practice, the diagnosis of diaphragm paralysis in the majority of cases rests principally on fluoroscopic evidence combined with clinical examination, positional changes in Vital Capacity (VC) and a measurable decrease in P_lmax.

Although most patients with new unilateral diaphragmatic dysfunction have minimal symptoms, some patients report persistent dyspnea on exertion and orthopnea with impairment of pulmonary reserve. Only limited options exist for treatment of persistent unilateral diaphragmatic paralysis. Diaphragmatic plication has been reported to produce symptomatic improvement along with significant improvement in FEV₁, FVC, lung volumes, and a reduction in positional changes of Vital Capacity.¹⁰ The procedure is performed through a thoracotomy incision and the diaphragm is plicated in successive layers until it is drawn taut. Shortening and stiffening of the diaphragm restores a more normal position

which reduces paradoxical motion. Both oxygenation and ventilation are improved. The procedure is reported to be durable, safe and effective.¹¹

We hope that this report will increase the awareness of the clinicians involved with scale-tomy to the potential of unilateral diaphragmatic paralysis and provide a suitable template for confirming the diagnosis.

References

1. Werner RA, Geiringer SR. Bilateral phrenic nerve palsy associated with open heart surgery. *Arch Phys Med Rehabil.* 1990;71:1000-1002.
2. Curtis JJ, Nawarawong W, Walls JT, et al. Elevated hemidiaphragm after cardiac operations: incidence, prognosis, and relationship to the use of topical ice slush. *Ann Thorac Surg.* 1989;48:764-768.
3. Abd AG, Braun NM, Baskin MI, O'Sullivan MM, Alkaltas DA. Diaphragmatic dysfunction after open heart surgery: Treatment with a rocking bed. *Ann Intern Med.* 1989;111:881-886.
4. Wilcox PG, Pare PD, Pardy RL. Recovery after unilateral phrenic injury associated with coronary artery revascularization. *Chest.* 1990;98:661-666.
5. Hadeed HA, Braun TW. Paralysis of the hemidiaphragm as a complication of internal jugular vein cannulation: report of a case. *J Oral Maxillofac Surg.* 1988;46:409-411.
6. Macklem PT. Normal and abnormal function of the diaphragm. *Thorax.* 1981;36:161-163.
7. Gibson GJ. Diaphragmatic paresis: pathophysiology, clinical features, and investigation. *Thorax.* 1989;44:960-970.
8. Piehler JM, Pairolero PC, Gracey DR, Bernitz PE. Unexplained diaphragmatic paralysis — A harbinger of malignant disease? *J Thorac Cardiovasc Surg.* 1982;84:861-864.
9. Williams TJ, Ahmad D, Morgan WKC. A clinical and roentgenographic correlation of diaphragmatic movement. *Arch Intern Med.* 1981;141:878-880.
10. Graham DR, Kaplan D, Evans CC, Hind CRK, Donnelly RJ. Diaphragmatic plication for unilateral diaphragmatic paralysis. A 10 year experience. *Ann Thorac Surg.* 1990;49:248-252.
11. Langer JC, Filler RM, Coles J, Edmonds JF. Plication of the diaphragm for infants and young children with phrenic nerve palsy. *J Ped Surg.* 1988;23:749-757.

Use of Laparoscopy in the Treatment of Acute and Chronic Right Lower Quadrant Pain

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Laparoscopy and the availability of procedures which can be easily performed through the laparoscope, including appendectomy, alter the surgeon's approach towards the management of right lower quadrant pain, both acute and chronic. Laparoscopy can be utilized in a variety of clinical settings, a number far greater than those patients which would otherwise be considered proper subjects for open appendectomy. Laparoscopy can be diagnostic, therapeutic, and also prophylactic. A two year experience of managing right lower quadrant pain in a rural hospital setting was reviewed; the procedure naturally lent itself to a variety of patients because of its ease, safety, and diagnostic accuracy.^{1,3,9} Chart review indicates an extraordinary degree of success in alleviating both acute and chronic symptoms; only one patient appears to have recurrent right lower quadrant pain out of our entire group.

The use of laparoscopy in this manner creates a paradigm for a type of medical practice that is problem-oriented instead of specialty-oriented. The pathological status of the appendix was not the only factor that predicted patients' clinical response to the procedure.

During our experience in managing right lower quadrant pain with laparoscopy, a number of advantages were identified: (1) Patients with indications for open appendectomy can return to work almost immediately. (2) A variety of other procedures were approached by the laparoscope including excision of ovarian cyst as well as adhesiolysis and prophylactic appendectomy where necessary, such as when findings suggest pelvic inflammatory disease or chronic right ovary pain syndromes or endometri-

osis. (3) Patients with acute abdominal pain and with a low to moderate degree of suspicion for appendicitis who otherwise might have been treated with an extended period of observation and multiple diagnostic procedures were treated with laparoscopy. (4) Patients with chronic and recurrent right lower quadrant pain, particularly those that had been subjected to multiple hospitalizations for such pain, were likewise treated. The present study did not undertake nor do we support a policy of routine incidental appendectomy at the time of laparoscopy in general.

Method

All patients with complaints of right lower quadrant pain presenting to a 210 bed rural hospital general surgery department over a 2-year period (10/91-10/93) were reviewed following surgical treatment. Elderly patients with complex surgical problems were not included in this review. Included in this review were cases managed both laparoscopically as well as with open appendectomy.

As regards the laparoscopically treated patients, the principles of the procedure already published were followed.² The insufflating needle was always placed in an orientation toward the left lower quadrant to avoid any possible phlegmon in the right lower quadrant. A three cannula technique was used, with the first cannula placed in the infraumbilical location, another cannula in the suprapubic midline, and another cannula in the right lower quadrant. The only complication with this group is noted in the chart. This patient had an increased length of stay due to conservative management for a rectus sheath hematoma from a suprapubic cannula lo-

cation that was placed just to the right of the midline. Precise midline placement of cannulae will avoid bleeding complications.

The three puncture technique allowed a complete diagnostic evaluation including evaluation of the pelvic organs, both ovaries, puncture or excision of ovarian cysts, and evaluation of endometriosis. Division of adhesions around appendix and right colon was possible and the small bowel was run. A variety of conditions such as PID, ileitis, mesenteric adenitis, etc., are easily diagnosed, avoiding the necessity for excessive preoperative evaluation of chronic cases. The appendix was grasped by tenaculum introduced through the right lower quadrant port and dissected with instruments introduced through the suprapubic port. Cautery and laser were not used because of the inherent danger to tissue; the mesoappendix could always be controlled with clips and dissected from the appendix. The base of the appendix was simply controlled with two vessel loops or with the endo GIA if the base of the appendix and cecum were involved in any inflammation. No attempt was made to cauterize the mucosa of the appendix or to duck the stump into the cecum. Fascia was not closed except for 12 mm puncture sites. Generally, closure of the site through which the appendix was extracted was not performed. A spoon-like grasper, used to grasp gallstones, was much more effective in removing the appendix than the usual toothed grasper used to remove a gallbladder.

Results

Sixty-five cases (Charts II & III) are grouped under the "acute" (severe right lower quadrant pain of less than about 72 hours of onset) indication. Twenty of these, with 80% positive pathology, were done using open appendectomy; these patients may have refused the laparoscopic approach; in others, at least initially, the operators were concerned about peritoneal findings in the right lower quadrant and abdominal distension though we became less concerned about this as our experience progressed.

The remaining 45 patients in the "acute" indication were evaluated using laparoscopy. All of these patients, by both direct interview and chart review, have experienced complete resolution of their pain. An attempt was made to survey these patients by mail, however the response was inadequate and these results were not included in this paper. The intervention in these cases was gener-

ally earlier in the course of the treatment of the pain than would have been done in the era when only open exploration was done, since the operator was secure in the knowledge that the procedure would provide an excellent diagnostic evaluation as well as treatment. Twenty-eight of the 45 appendixes removed were pathologically "normal." This gives a true-positive appendectomy rate in the laparoscopically treated group of about 38%.

This figure does not reflect patients' satisfaction with this procedure. All these patients had complete resolution of their pain. In addition they had rapid, efficient, and almost pain free work-up and treatment for their problem, regardless of whether the problem was acute appendicitis, blood collection in the pelvis from a hemorrhagic cyst, abscess, etc. Among the 28 cases with "normal" appendixes, a variety of pathology was noted including diverticulitis, cecal adhesions, ruptured ectopic pregnancy, PID, hemorrhagic and ruptured ovarian cysts, chronic appendiceal changes, pinworm, etc.

One of these patients was 6 weeks pregnant and diagnostic ultrasound could not rule out a right tubal pregnancy. Laparoscopic evaluation and appendectomy allowed both the removal of an acute appendix as well as evaluation of the right tube, which determined that the pregnancy was indeed intrauterine.

Fourteen patients were done in the "chronic" group (Chart I) for indications which included recurrent hospitalization or a long history of right lower quadrant pain, etc. This procedure avoided the necessity of time-consuming testing, including barium enema examination, colonoscopy, and ultrasound studies. All the patients in the chronic group, except for one who was found to have irritable bowel syndrome, had complete resolution of their pain with diagnostic laparoscopy accompanied by appendectomy. All of the appendixes removed were normal pathologically. A variety of other pathology was found including persistent hemorrhagic cyst of right ovary, PID, endometriosis, and adhesions with irritable bowel syndrome. One other patient had appendix pathology abnormal to the degree of showing serosal congestion; this was probably related to preoperative abortion of the appendicitis by antibiotic treatment.

Cost Benefit Analysis

In our hospital the charge for one day admission for laparoscopy with possible appendectomy is

Laparoscopy in the Treatment of Right Lower Quadrant Pain

\$1346, with an additional charge for a surgeon's fee which varies from \$410 to \$965. As such, the total charge to the patient would probably be from \$1800 to \$2400. The patient who undergoes open appendectomy will have charges of \$1060 for the first day, along with 1.7 days of care at \$286 plus the surgeon's fee: A range of \$1956-2556.

The patient undergoing conservative management of his pain will have charges similar to those for an open appendectomy (\$1489), along

with radiologist's fees of about \$165 for ultrasound and barium enema and additional charges for further tests, eg, colonoscopy, CT, etc.

In terms of hospital charges there is little difference between one set of charges and another, however three issues must be considered:

1. *Productivity*: The average nonunion worker returned to work within a week of surgery; the productivity of a single worker, in the coal mine for instance, is around \$3500 per day of coal.

Chart I
CHRONIC

| AGE | SEX | WBC | APPENDIX PATH | ASSOCIATED DIAGNOSIS | LOS | TOO Minutes |
|------|-----|--------|------------------|-----------------------------------------------|-----|----------------|
| 55 | M | 11,000 | Normol***** | | 1 | 72 |
| 26 | F | 10,400 | Normol | Persistent hemorrhagic cyst of right ovary | 2 | 49 |
| 33 | F | 7,200 | Normol | | 2 | 63 |
| 39 | F | 6,200 | Normal | PID, bilateral Corpus Luteum cysts | 4 | 46 |
| 13 | F | 8,900 | Normol | | 1 | 50 |
| 19 | F | 8,700 | Normol***** | Adhesions; irritable bowel syndrome | 1 | 41 |
| 38 | F | 10,000 | Normal | Endometriosis | 1 | 61 |
| 30 | F | 8,300 | Normal | Adhesions to vaginal cuff | 1 | 35 |
| 24 | F | 15,100 | Normol | Hemorrhagic corpus luteum cyst | 1 | 36 |
| ++13 | F | 7,300 | Normol | Adhesiolysis | 1 | 50 |
| ++23 | F | 13,300 | Normol | PID; ileitis; cysts | 3 | 35 |
| 18 | F | 7,200 | Normol | | 1 | 42 |
| ++33 | F | 8,100 | Normol | PID; ileitis; cysts | 1 | 59 |
| ++25 | F | 8,900 | Normol | 3 cm cyst R ovary, ? PID | 1 | 35 |

Chart II
ACUTE/OPEN

| | | | | | | |
|----|---|--------|--------|---------------------------|---|----|
| 9 | M | 22,600 | Acute | Peritonitis | 1 | 31 |
| 10 | F | 10,600 | Normol | High WBC with antibiotics | 2 | 29 |
| 9 | M | 18,900 | Acute | | 1 | 31 |
| 27 | M | 15,800 | Acute | | 4 | 61 |
| 13 | F | 15,500 | Acute | Peritonitis | 2 | 25 |
| 23 | F | 11,700 | Normal | 16 weeks pregnant | 2 | 30 |
| 8 | M | 15,400 | Acute | Abscess | 6 | 29 |
| 34 | M | 13,300 | Acute | | 2 | 24 |
| 2 | F | 10,500 | Acute | | 2 | 40 |
| 30 | M | 11,800 | Acute | Abscess | 6 | 39 |
| 9 | M | 22,000 | Acute | Pt weight 50 lbs | 2 | 21 |
| 8 | M | 9,800 | Normol | Porositis | 1 | 16 |
| 27 | F | 19,300 | Acute | Suppurative | 6 | 50 |
| 41 | M | 20,900 | Acute | Suppurative | 1 | 20 |
| 18 | F | 26,900 | Acute | Abscess | 1 | 52 |
| 31 | M | 13,500 | Acute | | 3 | 40 |
| 7 | F | 13,800 | Normal | Adenitis | 2 | 24 |
| 26 | M | 17,700 | Acute | Peritonitis | 2 | 28 |
| 44 | F | 17,600 | Acute | Peritonitis | 2 | 31 |
| 6 | M | 13,100 | Acute | Abscess | 5 | 42 |

Chart III
ACUTE/LAP

| | | | | | | |
|-----|---|--------|------------------|--------------------------------|-------|------|
| 66 | F | 14,300 | Narmal | Diverticular disease | 1 | 49 |
| 67 | F | 13,800 | Acute | Abscess, appendiceal | 2 | 50 |
| 31 | F | 8,100 | Narmal* | | 1 | 46 |
| 16 | M | 10,900 | Fecalith | | 1 | 50 |
| 22 | F | 9,000 | Narmal | Adhesions | 1 | 72 |
| 21 | F | 12,300 | Narmal** | Ruptured Ectopic** | 5** | 78** |
| 14 | M | 19,600 | Acute | | 1 | 51 |
| 29 | F | 11,300 | Narmal | Bil Ovarian cysts | 1 | 54 |
| 23 | M | 11,500 | Acute | | 1 | 60 |
| 22 | F | 13,300 | Acute | PID, Adhesions | 1 | 92 |
| 22 | F | 12,800 | Acute | Na Right tubal pregnancy*** | 2 | 54 |
| 16 | M | 15,000 | Narmal | | 1 | 40 |
| 24 | F | 15,100 | Narmal | Hemorrhagic right ovarian cyst | 1 | 36 |
| 23 | M | 27,000 | Sup Appendicitis | Abscess | 2 | 62 |
| 14 | F | 8,400 | Narmal | | 1 | 64 |
| 21 | F | 20,300 | Acute | Ruptured Corpus Luteum Cyst | 1 | 36 |
| 23 | M | 10,000 | Acute | | 1 | 54 |
| 31 | M | 16,600 | Acute | | 3**** | 72 |
| 25 | M | 16,200 | Narmal | | 1 | 55 |
| 16 | M | 15,000 | Narmal | | 1 | 40 |
| 23 | M | 27,000 | Acute | Gangrenous | 1 | 62 |
| +14 | F | 11,700 | Narmal | Adenitis, 4 cm cyst | 2 | 35 |
| +25 | M | 7,600 | Narmal | | 1 | 32 |
| +18 | F | 10,800 | Narmal | Adhesions | 1 | 40 |
| 37 | F | 10,300 | Acute | Adhesions | 1 | 32 |
| 11 | M | 11,900 | Acute | Perforated | 1 | 45 |
| +26 | F | 9,600 | Narmal | PID | 1 | 35 |
| 53 | F | 14,200 | Acute | Suppurative | 6 | 41 |
| 51 | M | 16,000 | Narmal | Bilateral hernia | 1 | 30 |
| 14 | M | 15,000 | Narmal | | 1 | 46 |
| 11 | M | 19,000 | Acute | Suppurative | 3 | 32 |
| +43 | F | 10,900 | Narmal | Corpus luteum cyst | 1 | 28 |
| 18 | F | 9,800 | Narmal | EBV infection | 3 | 35 |
| +61 | F | 17,600 | Acute | Suppurative | 1 | 51 |
| +25 | F | 9,000 | Narmal | Corpus luteum cyst | 2 | 35 |
| 27 | F | 7,600 | Narmal | Corpus luteum cyst | 2 | 30 |
| 15 | M | 12,500 | Acute | | 1 | 40 |
| 32 | F | 22,400 | Narmal | Ileitis | 2 | 42 |
| 32 | F | 12,600 | Narmal | PID | 3 | 29 |
| 33 | F | 10,900 | Narmal | PID | 1 | 30 |
| 39 | F | 13,500 | Acute | Suppurative | 1 | 42 |
| 38 | F | 11,200 | Narmal | Fallicular cyst | 1 | 42 |
| +23 | F | 6,600 | Narmal | Adhesions | 1 | 42 |
| 21 | F | 15,000 | Narmal | | 1 | 42 |
| 13 | M | 8,400 | Narmal | | 1 | 41 |

+ Persistent pain despite 2 or more days of observation.

++ Indicates nondiagnostic gyneco-ultrasound or CT scan.

* Prominent lymphatic follicles & germinal center's (appendix).

** Ruptured ectopic (case not included in statistics).

*** 6 weeks pregnant.

**** Complication rectus sheath: Hematoma.

***** Seral congestion —? aborted by antibiotics.

***** Persistent pain — procedure unsuccessful.

Laparoscopy in the Treatment of Right Lower Quadrant Pain

Nonunion workers following open appendectomy usually require about a month to recuperate.

2. *Comfort:* Patients responded well to rapid diagnosis afforded by laparoscopy even though out of our "acute" group of 45, 24 "extra" appendixes were removed. (This number results from 17 appendectomies that were pathologically "positive," which number is augmented by a predicted 25% of negative open explorations which would have resulted in 21 cases under an idealized regime; twenty-one from forty-five is twenty-four.)

3. *Cost:* In view of hospitals' efforts to shift unfunded Medicare costs to areas such as OR, it makes no sense to compare costs: Laparoscopy, even with the surgeon's fee, OR and anesthesia time should not "cost" any more than hours of time in a radiology suite with ultrasound, CT and fluoro with radiologist present.

Summary

Evaluation and treatment of right lower quadrant pain using laparoscopy changes the approach of the surgeon who heretofore had to rely on open exploration for these processes. Laparoscopy can be diagnostic, prophylactic, and therapeutic, as opposed to open procedures, which, due to the significant morbidity, have mainly been confined to a therapeutic role. Laparoscopy with appendectomy is safe:¹ it eliminates the need for extensive radiologic procedures and a period of observation in some patients, and it results in "improved cosmesis, a decrease in morbidity, a reduction of wound pain, shortened hospital stay, and a quicker return to normal life."³ These patients generally return to work within a matter of days following their procedure, even when their work is heavy labor.

The role of laparoscopy with appendectomy fits between a number of extreme positions, all of which it renders in an unfavorable light: The position of classical appendectomy which maintains an ideal of operating only on patients with true pathologically proven appendicitis;¹⁰ a position of considering appendectomy to be a routine procedure as part of every laparoscopy; as well as the procedure of the routine practice of diagnostic laparoscopy followed by open appendectomy only if deemed necessary due to gross findings.⁴ The role of laparoscopy with appendectomy is more easily defined as a tolerable compromise between these three extreme positions.

The diagnosis of appendicitis can be particularly difficult in women of childbearing age.⁵ "In some series close to half the appendixes removed in this group are normal," according to one author.⁶ In our total group, 49 of 79 were female (many of them young), a female percentage of 62%.

Patients as young as 11, down to a weight limit of around 60 pounds, were done using adult instrumentation.⁷ Costs were analyzed without showing any apparent advantage to any particular mode of treatment, however this analysis does not account for a number of significant factors. The average length of hospitalization was 1.25 days (except the one patient with a ruptured ectopic pregnancy) in that group who were done using laparoscopy. By contrast, in the "acute/open" group the length of stay was 2.7 days, more than twice the length of hospitalization in the laparoscopically treated group. An outline of our cost analysis reveals a substantial advantage for laparoscopic vs open procedures, in view of earlier return to work.

The possibility exists that the low morbidity and general safety of laparoscopy accompanied by appendectomy will make it possible to finally determine whether "chronic appendicitis" is a real or only an imagined entity. Indeed, it is a concern that gross evaluation of the appendix using laparoscopic examination alone, unaccompanied by microscopic evaluation, may miss some cases of early acute appendicitis.⁸

In as much as all hospital and clinic records in our center are maintained in one file and that this hospital is the only hospital within a 35 mile radius, no separate system to record post operative pain complaints was maintained; however, it was possible to review all charts in depth to determine this information.

Only one patient out of our entire laparoscopy group appeared to have persistent pain following her diagnosis and treatment laparoscopically. We did attempt to survey the patients, but the results were substantially inadequate for an inclusion in the study.

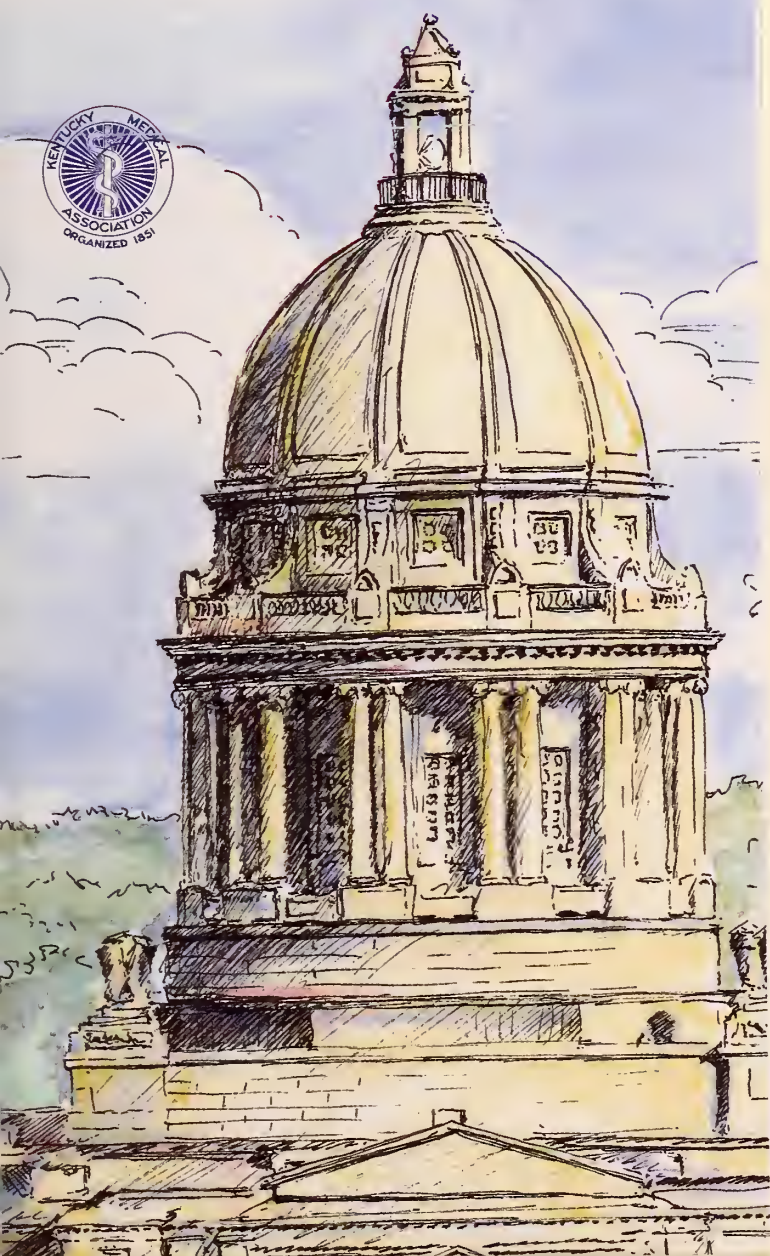
Surgeons have strongly held opinions about the conditions under which appendectomies should be done; authors have combed thousands of cases to find elusive "recurrent" appendix.^{11,19} In this atmosphere, even statements such as Zuidema's,²⁰ "Patients in whom the problems of diagnosis may be encountered are those complaining of recurrent attacks of abdominal pain. The term 'chronic appendicitis' is unsavory to the modern

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1996

KMA

Legislative Handbook



Cover design by Lee Wade of Louisville

FOREWORD

The 1996 Kentucky General Assembly convened on January 2. The KMA Legislative Quick Action Committee will meet in Frankfort on a weekly basis to establish positions on various legislative proposals and direct the overall effort.

However, the major lobbying effort must rest with the KMA Key Contacts and physician constituents of the members of the Kentucky General Assembly. The most important contribution you can make is to take the time to write a personal letter to your legislator outlining your personal concerns, particularly as they relate to your patients. Follow up that letter with a phone call. Then urge your fellow physicians to do the same.

If you have questions during the Session, don't hesitate to contact your Trustee, KMA officers, or staff. We are interested in your views and need your full support during these difficult times.



Wally O. Montgomery, MD

The Kentucky Medical Association gratefully acknowledges the Legislative Research Commission for its cooperation in providing photographs and much of the information in this publication.

You May Contact Your Legislator By Phone

When the General Assembly is in session, you may call your legislators in Frankfort at the following numbers:

Legislative Offices (502) 564-8100
Legislative Message Ctr 1-800-592-4557
(Operator takes message for your legislator)

KMA Officials

If you have questions during the Session, don't hesitate to contact your Trustee, KMA Officers, or staff. The following numbers may be used:

KMA Headquarters (502) 426-6200
Wally Montgomery, MD (502) 441-4300
(Chair, Committee on State Legislative Activities)
Danny M. Clark, MD (606) 679-8391
(KMA President)
Harry W. Carloss, MD (502) 441-4343
(Chair, Board of Trustees)

KMA Lobbyists (home phone numbers)

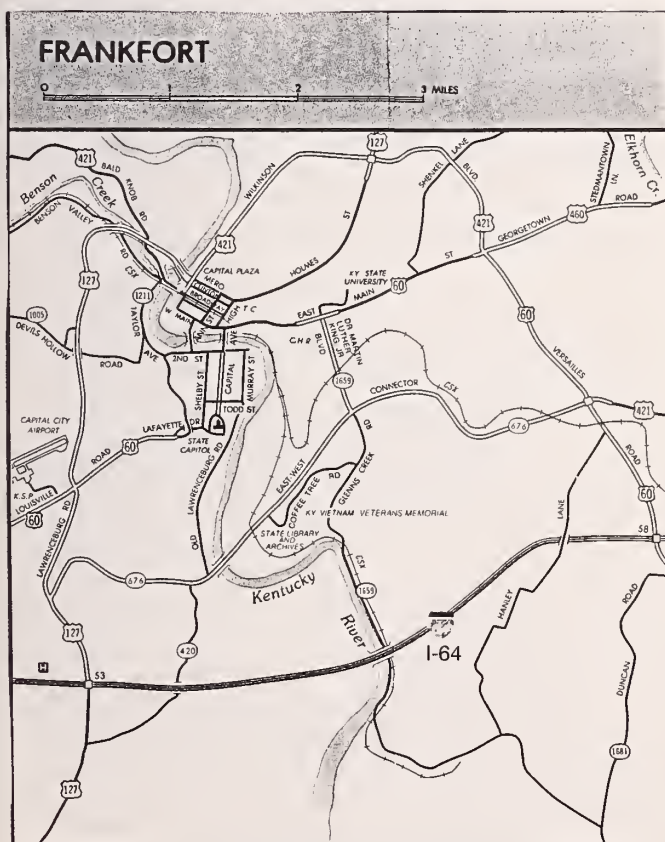
Don R. Chasteen, Louisville (502) 429-5126
David W. Carby, Louisville (502) 895-8339
John P. Cooper, Georgetown (502) 868-9128
William E. Doll, Jr, Frankfort (502) 223-3150

*"Every person owes part of his time
and money to the business or industry
in which he is engaged. No person has
a moral right to withhold support from
an organization that is striving to
improve conditions within his sphere."*

— TEDDY ROOSEVELT

Coming to Frankfort?

1. Contact your legislator and schedule a visit.
2. Contact KMA and arrange for a briefing by a KMA lobbyist prior to your legislative visit.
3. If your legislator is on a health-related committee, visit on a day the committee meets. You'll get a real perspective of their activities.
4. Time your visit — visit early and discuss important issues prior to a vote.
5. Keep up during the Session — drop a note thanking your legislators — reminding them of your position.
6. After the Session — remember their record on election day.



Writing Effective Letters to Legislators

In communicating your ideas and positions on issues with legislators, writing a letter is the most effective. The following tips may help in presenting your views.

1. Use personal stationery.
2. Indicate which bill or issue you are addressing.
3. Get to the point! Do you support or oppose the bill.
4. Provide concrete, credible information on the legislation's impact.
5. Act promptly. Good letters arriving after a vote are useless.
6. Keep letters short. One-page letters have more impact than long ones.
7. If legislators do what you ask, send a thank you letter.

Letters can be mailed to the following address:

The Honorable (legislator's name)
Kentucky State Senate **OR**
Kentucky House of Representatives
Frankfort, KY 40601

"Every individual has a role to play. A person who is not interested in politics is not minding his own business."

— PERICLES

Eight Major Mistakes in Dealing With Legislators

1. Assume each legislator is a walking encyclopedia on every pending issue.

During a normal session of the General Assembly, approximately 1500 different bills are introduced with about one third becoming law. That's a lot of legislation to read, review and remember. It's virtually impossible for every legislator to know every bill, chapter and verse. Individual legislators are most familiar with three types of bills — those they personally sponsor, those that come before committees on which they serve, and those that someone in their district has urged them to either support or oppose.

2. Expect a commitment on the spot.

Most legislators are thoughtful, deliberate types, who make a point to seek out all sides of a particular issue before taking a position. Remember that a good politician generally checks out the water's depth before diving.

3. Come armed without the facts.

Smoke and mirrors won't do the job in winning a legislator over. You must demonstrate through tangible evidence supported by facts that a particular action is both desirable and justifiable — and the ultimate burden of proof is on you.

4. Forget there's always another side to the issue.

Each state representative has an average of 37,280 constituents; each state senator has an average of 98,105. You can be sure that there's at least one constituent, if not more, who has a different position on an issue and, just like you, expects to have his or her voice heard. As one veteran officeholder is fond of saying, "Some of my friends are for this bill, some are against — and I'm sticking with my friends!"

5. Run down the opposition.

Name-calling or derogatory remarks don't win friends and influence legislation. If your issue can't stand on its own merit, then your cause is already lost. Besides, your legislator's brother-in-law might be a key member of the group that's on the other side of the fence!

6. Burn your bridges when you don't win.

Working with the legislators is an investment that may not pay off immediately. Don't burn your bridges if results aren't immediately forthcoming.

7. Fail to say thank you.

Even though meeting with constituents comes with the territory for legislators, it's still an act that should be acknowledged. A thank-you note for taking the time to meet with you is always in order.

8. Leave never to be heard from again.

One phone call or visit isn't enough. That means keeping in touch to let the legislator know that your interest is not a passing fancy. Stay on top of developments relating to your issue so that when new and relevant information becomes available, you can pass it along.

THERE'S A DOCTOR IN THE HOUSE
..... AND SENATE
..... AND EXECUTIVE BRANCH



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| Floor Leader | Dan Kelly |
| Caucus Chairman | Tom Buford |
| Whip | Richard Roeding |

SENATE



SENATORS BY DISTRICT

SENATE

- 1 Jeff Green
- 2 Robert J "Bob" Leeper
- 3 Joey Pendleton
- 4 Paul Herron, Jr
- 5 Virgil Moore
- 6 Kim L Nelson
- 7 Lindy Casebier
- 8 David E Boswell, Sr
- 9 Walter A Baker
- 10 Elizabeth J Tori
- 11 Richard L Roeding
- 12 Tim Philpot
- 13 Mike Moloney
- 14 Dan Kelly
- 15 James D Crase, MD
- 16 David L Williams
- 17 Charles W Berger
- 18 Charlie Borders
- 19 Tim Shaughnessy
- 20 Fred F Bradley
- 21 Albert L Robinson
- 22 Tom Buford
- 23 Joseph U Meyer
- 24 Gex "Jay" Williams, III
- 25 John David Preston
- 26 Ernie Harris
- 27 Walter Blevins, Jr, DMD
- 28 John A "Eck" Rose
- 29 Benny Ray Bailey
- 30 Denny Nunnelley
- 31 Kelsey E Friend
- 32 Nick Kafoglis, MD
- 33 Gerald A Neal
- 34 Barry Metcalf
- 35 David K Karem
- 36 Julie Rose
- 37 Larry Saunders
- 38 Dan "Malano" Seum

The Kentucky General Assembly has been required by the Supreme Court to re-district the state of Kentucky. District numbers listed above may not apply throughout the Session.

COMMITTEE ROSTER

1996 KENTUCKY GENERAL ASSEMBLY

SENATE

Committees of the Senate

Appropriations & Revenue

| | |
|-------------------|-------------|
| Moloney — Chair | Pendleton |
| Bailey | Baker |
| Berger | Borders |
| Blevins | Casebier |
| Kafoglis | Preston |
| Neal — Vice Chair | G. Williams |

Banking & Insurance

| | |
|----------------------|----------|
| Saunders — Chair | Borders |
| Blevins — Vice Chair | Buford |
| Bradley | Casebier |
| Green | Metcalf |
| Herron | Roeding |
| Shaughnessy | |

Economic Development & Labor

| | |
|-------------------|-------------|
| Leeper — Chair | Moore |
| Boswell | Preston |
| Friend | Robinson |
| Maloney | J. Rose |
| Seum — Vice Chair | D. Williams |
| Shaughnessy | |

Health & Welfare

| | |
|------------------------|---------|
| Bailey — Chair | Buford |
| Herron | Crane |
| Meyer | Philpot |
| Nunnelley | Roeding |
| Pendleton — Vice Chair | J. Rose |
| Saunders | |

Judiciary

| | |
|---------------------|-------------|
| Friend — Chair | Harris |
| Berger — Vice Chair | Philpot |
| Karem | Roeding |
| Moloney | Tori |
| Neal | D. Williams |
| Nelson | |

Licensure & Occupations

| | |
|-----------------------|-------------|
| Boswell — Chair | Buford |
| Bradley | Cruse |
| Green | Metcalf |
| Nunnelley | Philpot |
| Saunders — Vice Chair | G. Williams |
| Seum | |

State Government

| | |
|---------------------|----------|
| Shaughnessy — Chair | E. Rose |
| Friend | Baker |
| Kafoglis | Harris |
| Karem | Preston |
| Leeper | Robinson |
| Meyer — Vice Chair | Tori |

Transportation

| | |
|------------------------|----------|
| Nelson — Chair | Cruse |
| Blevins | Kelly |
| Boswell | Metcalf |
| Nunnelley — Vice Chair | Moore |
| E. Rose | Robinson |
| Seum | |

Rules

| | |
|-------------------|----------|
| Karem — Chair | Kafoglis |
| Rose — Vice Chair | Kelly |
| Berger | Neal |
| Bradley | Roeding |
| Buford | |

NOTE: The above-listed committees are those to which health and medical issues are generally referred.

"Being in politics is like being a football coach. You have to be smart enough to understand the game and dumb enough to think it's important."

— EUGENE McCARTHY

KENTUCKY STATE SENATE

Benny Ray Bailey D-29

PO Box 849

Hindman, KY 41822

(606) 785-3164 (H)

(606) 785-5327 (O)

Breathitt, Floyd, Knott, Leslie, Perry

Profession: Clinic Administrator

Education: Alice Lloyd College,

AA; Pikeville College, BA;

Indiana State U, MS; Ohio

University, PhD

Committee Assignments:

Appropriations & Revenue,

Health & Welfare



Walter A. Baker R-9

917 South Green Street

Glasgow, KY 42141

(502) 651-3715 (H)

(502) 651-8116 (O)

Allen, Barren, Butler, Edmonson,

Metcalfe, Ohio, Simpson

Profession: Attorney

Education: Harvard College, AB;

Harvard Law School, LLB

Committee Assignments:

Appropriations & Revenue, State

Government



Charles W. Berger D-17

PO Box 764

Harlan, KY 40831

(606) 753-3180 (H)

(606) 573-2962 (O)

Bell, Harlan, Leslie, Letcher

Profession: Attorney

Education: U of Tennessee, JD

Committee Assignments:

Appropriations & Revenue,

Judiciary, Rules



Walter Blevins Jr D-27

903 North Main Street
West Liberty, KY 41472

(606) 743-1212 (H)

(606) 743-1200 (O)

Clay, Elliott, Jackson, Lee,
Magoffin, Menifee, Morgan,
Owsley, Rockcastle, Rowan,
Wolfe

Profession: Dentist

Education: U of Kentucky, DMD

Committee Assignments:

Appropriations & Revenue,

Banking & Insurance,

Transportation



Charlie Borders R-18

330 Seaton Drive

Russell, KY 41169

(606) 836-1721 (H)

Bracken, Carter, Greenup, Lewis,
Mason

Profession: Oil Executive

Education: Morehead, MBA

Committee Assignments:

Agriculture & Natural Resources,

Banking & Insurance



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David E. Boswell D-8

2130 Woodland Drive

Owensboro, KY 42301

(502) 684-2490 (H)

(502) 771-4921 (O)

Daviess, Hancock, Ohio

Profession: Self-employed

Education: Western KY U; Brescia

Committee Assignments:

Transportation



Fred Bradley D-20

855 South Benson Road

Frankfort, KY 40601

(502) 564-2294 (H)

(502) 227-4443 (O)

Bullitt, Franklin, Shelby, Spencer

Profession: Attorney, etc

Education: U of Kentucky, JD

Committee Assignments:

Agriculture & Natural Resources,

Banking & Insurance, Rules



Tom Buford R-22

105 Crosswoods Place
Nicholasville, KY 40356
(606) 223-7171 (H)
Anderson, Boyle, Garrard,
Jessamine, Mercer
Profession: Contractor
Education: U of K, BS; American
Institute of Banking
Committee Assignments:
Banking & Insurance, Health &
Welfare, Rules



Lindy Casebier R-7

3304 Hardwood Forest Drive
Louisville, KY 40214
(502) 935-4085 (H)
Jefferson
Profession: Teacher
Education: U of L, MA
Committee Assignments:
Appropriations & Revenue,
Banking & Insurance



James D. Crase MD R-15

602 Clifty Road
Somerset, KY 42501
(606) 679-9268 (H)
(606) 679-3698 (O)
McCreary, Pulaski, Whitley
Profession: Physician
Education: U of L, MD
Committee Assignments: Health &
Welfare, Transportation



Kelsey E. Friend D-31

PO Box 512
Pikeville, KY 41501
(606) 437-4026 (H)
(606) 437-4616 (O)
Floyd, Martin, Pike
Profession: Attorney
Education: Duke U, LL.M.
Committee Assignments: Economic
Development & Labor, State
Government



Jeff Green D-1

PO Box 315
Mayfield, KY 42006
(502) 247-8522 (H)
(502) 247-5199 (O)
Calloway, Carlisle, Christian,
Fulton, Graves, Hickman, Trigg
Profession: Attorney
Education: Murray State U; Chase
College of Law, JD
Committee Assignments:
Agriculture & Natural Resources
Banking Insurance



Ernie Harris R-26

4306 South Highway 1694
Prospect, KY 40059
(502) 363-1436 (H)
(502) 241-2841 (O)
Carroll, Grant, Henry, Oldham,
Owen, Pendleton, Scott, Trimble
Profession: Pilot, Farmer
Education: U of K, Webster U
Committee Assignments: Judiciary,
State Government



S
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Paul Herron Jr D-4

623 Barret Boulevard, Apt G
Henderson, KY 42420
(502) 826-6216 (H)
(502) 827-5480 (O)
Crittenden, Henderson, Livingston,
Lyon, Union, Webster
Profession: Real Estate
Committee Assignments:
Agriculture & Natural Resources,
Banking & Insurance, Health &
Welfare



Nick Kafoglis MD D-32

1008 Newman Drive
Bowling Green, KY 42101
(502) 781-3414 (H)
(502) 843-4127 (O)
Logan, Warren
Profession: Physician
Education: U of Pennsylvania, MD
Committee Assignments:
Appropriations & Revenue, State
Government, Transportation,
Rules



David K. Karem D-35

2439 Ransdell Avenue

Louisville, KY 40204

(502) 574-3768 (H)

(502) 454-4174 (O)

Jefferson

Profession: Attorney

Education: U of L, JD

Committee Assignments: Judiciary,
Rules, State Government



Dan Kelly R-14

324 West Main Street

Springfield, KY 40069

(606) 336-7723 (H)

(606) 336-9048 (O)

Bullitt, Marion, Nelson, Taylor,
Washington

Profession: Attorney

Education: U of L, JD

Committee Assignments:
Agriculture & Natural Resources,
Rules, Transportation



Robert J. Leeper D-2

229 South Friendship Road

Paducah, KY 42001

(502) 554-9637 (H)

(502) 554-2771 (O)

Ballard, McCracken, Marshall

Profession: Chiropractor

Education: Sherman Chiropractic
School

Committee Assignments:
Agriculture & Natural Resources,
Economic Development & Labor,
State Government



Barry Metcalf R-34

141 Alycia Drive

Richmond, KY 40475

(606) 624-0848 (H)

(606) 624-8387 (O)

Fayette, Garrard, Lincoln, Madison

Profession: Contractor

Education: Eastern KY U, BS & BA

Committee Assignments:
Banking & Insurance,
Transportation



Joseph U. Meyer D-23
 106 West Eleventh Street
 Covington, KY 41011
 (606) 491-9696 (H)
 (606) 431-0413 (O)
 Campbell, Kenton
 Profession: Attorney
 Education: Chase College of Law,
 JD
 Committee Assignments: Health &
 Welfare, State Government

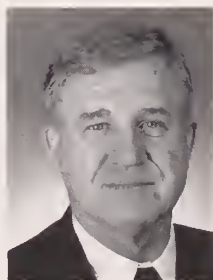


Michael R. Moloney D-13
 259 West Short Street
 Lexington, KY 40507
 (606) 255-7946 (H)
 (606) 268-1784 (O)
 Fayette
 Profession: Attorney
 Education: Xavier U, BS; U of K,
 LLB
 Committee Assignments:
 Appropriations & Revenue,
 Judiciary



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Virgil Moore R-5
 PO Box 165
 Leitchfield, KY 42755
 (502) 259-3430 (H)
 Breckinridge, Grayson, Hart,
 LaRue, Meade, Ohio
 Profession: Farmer
 Education: Eastern Kentucky U, BS
 Committee Assignments:
 Agriculture & Natural Resources,
 Economic Development & Labor,
 Transportation



Gerald A. Neal D-33
 1718 West Jefferson
 Louisville, KY 40203
 (502) 584-8500 (H)
 (502) 778-1178 (O)
 Jefferson
 Profession: Attorney
 Education: KY State U, BA;
 U of L, JD; U of Michigan
 Committee Assignments:
 Appropriations & Revenue,
 Judiciary, Rules



Kim L. Nelson D-6

PO Box 984

Madisonville, KY 42431

(502) 825-9022 (H)

(502) 825-3661 (O)

Caldwell, Crittenden, Hopkins,

McLean, Muhlenberg

Profession: CPA

Education: Murray State U, BS

Committee Assignments: Judiciary,

Transportation



Denny Nunnelley D-30

100 South Gratz

Midway, KY 40347

(606) 223-2667 (H)

(606) 846-4872 (O)

Bourbon, Fayette, Harrison,

Nicholas, Robertson, Scott,

Woodford

Profession: Business Owner

Education: Morehead State U

Committee Assignments:

Transportation



Joey Pendleton D-3

905 Hurst Drive

Hopkinsville, KY 42240

(502) 885-1639 (H)

Butler, Christian, Logan,

Muhlenberg, Todd

Profession: Dairy Farmer

Committee Assignments:

Agriculture & Natural Resources,

Appropriations & Revenue,

Health & Welfare



Timothy N. Philpot R-12

3060 Harrodsburg Road, Ste 205

Lexington, KY 40504

(606) 224-4999 (H)

(606) 224-3093 (O)

Fayette

Profession: Attorney

Education: U of K, BA, JD

Committee Assignments: Judiciary



John David Preston R-25

PO Box 808

Paintsville, KY 41240

(606) 789-3578 (H)

(606) 789-5265 (O)

Boyd, Elliott, Johnson, Lawrence,
Magoffin

Profession: Attorney

Education: Harvard, JD

Committee Assignments:

Appropriations & Revenue,
Economic Development & Labor,
State Government



Albert Robinson R-21

1249 South Main Street

London, KY 40741

(606) 878-6877 (H)

(606) 834-6606 (O)

Clay, Knox, Laurel, Leslie

Profession: Real Estate

Education: Cumberland College

Committee Assignments: State
Government



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Richard L. Roeding R-11

2227 Grace Avenue

Ft Mitchell, KY 41017

(606) 331-1684 (H)

Boone, Campbell, Kenton

Profession: Pharmacist

Education: Xavier U; U of
Cincinnati

Committee Assignments:

Appropriations & Revenue,
Banking & Insurance, Health &
Welfare



John A. "Eck" Rose D-28

PO Box 511

Winchester, KY 40391

(606) 745-3071 (H)

(606) 744-4338 (O)

Bath, Clark, Estill, Fleming,
Montgomery, Powell

Profession: Realtor/Farm

Education: Eastern KY U, BS

Committee Assignments: State
Government, Transportation



Julie Carman Rose R-36

4600 Doe Springs Court

Louisville, KY 40241

(502) 499-5885 (H)

(502) 228-7673 (O)

Jefferson

Profession: Business Owner

Education: U of L, BS

Committee Assignments: Economic
Development & Labor, Health &
Welfare



Larry L. Saunders D-37

736 Palatka Road

Louisville, KY 40214

(502) 584-8000 (H)

(502) 361-7871 (O)

Bullitt, Jefferson

Profession: Attorney

Education: U of L, BA, JD

Committee Assignments:
Banking & Insurance, Health &
Welfare



Dan "Melano" Seum D-38

4709 South Second Street

Louisville, KY 40214

(502) 366-3500 (H)

(502) 366-4748 (O)

Jefferson

Profession: Restaurant Owner

Committee Assignments: Economic
Development & Labor,
Transportation



Tim Shaughnessy D-19

250 East Liberty, Suite 103

Louisville, KY 40202

(502) 584-1920 (H)

(502) 267-5063 (O)

Jefferson

Profession: Hospital VP

Education: Jefferson Community
College; U of L, BS; Bellarmine
College, MBA

Committee Assignments:
Banking & Insurance, Economic
Development & Labor, State
Government



Elizabeth Tori R-10

2851 West Wilson Road
Radcliff, KY 40160
(502) 351-1829 (H)

Hardin, LaRue

Profession: Business Owner

Committee Assignments:

Agriculture & Natural Resources,
Judiciary, State Government



Gex "Jay" Williams III R-24

14142 Walton-Verona Road
Verona, KY 41092

(513) 579-0455 (H)

(606) 485-1111 (O)

Boone, Campbell, Gallatin,
Kenton

Profession: Finances

Education: U of Florida, BA

Committee Assignments:

Appropriations & Revenue



David L. Williams R-16

PO Box 666

Burkesville, KY 42717

(502) 864-5636 (H)

(502) 864-2640 (O)

Adair, Casey, Clinton,
Cumberland, Green, Monroe,
Russell, Wayne

Profession: Attorney

Education: U of L, JD

Committee Assignments: Economic
Development & Labor, Judiciary



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"Good legislation is in the eye of the beholder."

— CARL COOPER, JR, MD

KMA PRESIDENT 1978-1979

HOUSE LEADERSHIP

ELECTIVE OFFICERS

Speaker
Speaker Pro Tem

Jody Richards
Larry Clark

PARTY LEADERS

Democrats

Floor Leader
Caucus Chairman
Whip

Gregory D. Stumbo
James P. Callahan
Kenny Rapier

Republicans

Floor Leader
Caucus Chairman
Whip

Danny Ford
Stan Cave
Charlie Walton



REPRESENTATIVES BY DISTRICT

HOUSE

- | | |
|------------------------------|----------------------------|
| 1 Charles R. Geveden | 51 Ray H. Altman |
| 2 Fred L. Nesler | 52 Jeffrey "Jeff" Buis |
| 3 A. Frank Rasche | 53 Ray Mullinix |
| 4 Kathy Hogancamp | 54 Joe Clarke |
| 5 Freed Curd | 55 Jack L. Coleman Jr |
| 6 J. R. Gray | 56 Joe Barrows |
| 7 John A. Arnold Jr | 57 H. "Gippy" Graham |
| 8 H. Ramsey Morris Jr | 58 Marshall Long |
| 9 James E. "Jim" Bruce | 59 James F. Zimmerman |
| 10 Joseph "Eddie" Ballard | 60 Paul H. Marcotte |
| 11 Gross C. Lindsay | 61 Royce W. Adams |
| 12 Jim Gooch Jr | 62 Mark Farrow |
| 13 Brian J. Crall | 63 Richard Murgatroyd |
| 14 Mark A. Treesh | 64 Thomas R. Kerr |
| 15 Charles "Preacher" Nelson | 65 Arnold Simpson |
| 16 Sheldon E. Baugh | 66 Charlie Walton |
| 17 Willard C. "Woody" Allen | 67 James "Jim" Callahan |
| 18 Dwight D. Butler | 68 Katie K. Stine |
| 19 Richard "Richie" Sanders | 69 Jon David Reinhardt |
| 20 Jody Richards | 70 Pete Worthington |
| 21 vacant | 71 John Will Stacy |
| 22 Richard A. Turner | 72 Jim Lovell |
| 23 Stephen R. "Steve" Nunn | 73 Drew Graham |
| 24 William U. Scott | 74 Adrian K. Arnold |
| 25 Jimmie Lee | 75 Ernesto Scorsone |
| 26 Kaye Bondurant | 76 Ruth Ann Palumbo |
| 27 Mark S. Brown | 77 Jesse Crenshaw |
| 28 Bill Lile | 78 Ernest L. Fletcher, MD |
| 29 Dave Stengel | 79 Lawrence Brandstetter |
| 30 Thomas J. "Tom" Burch | 80 Danny R. Ford |
| 31 Steven R. "Steve" Riggs | 81 Harry Moberly Jr |
| 32 Anne M. Northup | 82 Charles L. Siler |
| 33 Bob Heleringer | 83 Thomas "Tommy" Todd |
| 34 Mary Lou Marzian | 84 Clarence D. Noland Jr |
| 35 Jim Wayne | 85 Tom Jensen |
| 36 Lonnie N. Napier | 86 Elbert R. Hampton |
| 37 Perry B. Clark | 87 Michael "Mike" Bowling |
| 38 Denver Butler | 88 Rick Fox |
| 39 Robert R. Damron | 89 Jim Maggard |
| 40 vacant | 90 Barbara W. Colter |
| 41 Thomas N. Riner | 91 Paul Mason |
| 42 vacant | 92 Donnie Newsome |
| 43 E. Porter Hatcher Jr | 93 Kelsey E. Friend Jr |
| 44 Joni Jenkins | 94 Herbie Deskins Jr |
| 45 Stanton "Stan" Cave | 95 Greg Stumbo |
| 46 Larry Clark | 96 Walter Gee |
| 47 Jon Ackerson | 97 Hubert Collins |
| 48 Bob M. DeWeese, MD | 98 Ronald R. "Ron" Cyrus |
| 49 Allen Maricle | 99 Rocky Adkins |
| 50 Kenny Rapier | 100 Donald B. "Don" Farley |

The Kentucky General Assembly has been required by the Supreme Court to re-district the state of Kentucky. District numbers listed above may not apply throughout the Session.

COMMITTEE ROSTER

1996 KENTUCKY GENERAL ASSEMBLY

Committees of the House

Appropriations & Revenue

Harry Moberly — Chair
 Charles Geveden — Vice Chair
 Bob Heleringer — Vice Chair
 Royce Adams
 Rocky Adkins
 Joe Barrows
 Mark Brown
 Jim Callahan
 Larry Clark
 Richard Fox
 Porter Hatcher, Jr
 Jimmie Lee
 Marshall Long
 Paul Mason

Ruth Ann Palumbo
 Kenny Rapier
 Ernesto Scorsone
 John Stacy
 Pete Worthington
 Ray Altman
 Donald Farley
 Danny Ford
 Lonnie Napier
 Clarence Noland
 Anne Northup
 Tommy Todd
 Mark Treesh
 Richard Turner

Business Organizations & Professions

Denver Butler — Chair
 Robert Damron — Vice Chair
 Porter Hatcher, Jr — Vice Chair
 Jon Ackerson
 John Arnold, Jr
 Tom Burch
 Larry Clark
 J. R. Gray

Ruth Ann Palumbo
 Woody Allen
 Ernest Fletcher
 Bill Lile
 Paul Marcotte
 Allen Maricle
 Jon David Reinhardt

Banking & Insurance

Eddie Ballard — Vice Chair
 James Gooch — Vice Chair
 Ray Altman — Vice Chair
 James Bruce
 Herbie Deskins
 Mark Farrow
 Porter Hatcher, Jr
 Marshall Long
 Ramsey Morris
 Frank Rasche

Steven Riggs
 Arnold Simpson
 David Stengel
 Jon Ackerson
 Sheldon Baugh
 Stanton Cave
 Brian Crall
 Elbert Hampton
 Mark Treesh

Elections & Constitutional Amendments

Adrian Arnold — Chair
 Perry Clark — Vice Chair
 Gross Lindsay — Vice Chair
 Thomas Jensen — Vice Chair
 Joe Clarke
 Freed Curd

Mary Lou Marzian
 Arnold Simpson
 Jon Ackerson
 Woody Allen
 Allen Maricle

Health & Welfare

Tom Burch — Chair
 Jesse Crenshaw — Vice Chair
 Paul Mason — Vice Chair
 Bob DeWeese — Vice Chair
 Tommy Todd — Vice Chair
 John Arnold, Jr
 Perry Clark
 Robert Damron
 James Gooch

Mary Lou Marzian
 Ramsey Morris
 Donnie Newsome
 Ruth Ann Palumbo
 Ernesto Scorsone
 Ernest Fletcher
 Bob Heleringer
 Stephen Nunn
 Katie Stine

Judiciary

Michael Bowling — Chair
 Charles Geveden — Vice Chair
 James Lovell — Vice Chair
 Stanton Cave — Vice Chair
 Perry Clark
 Jesse Crenshaw
 Herbie Deskins
 Kelsey Friend, Jr
 Thomas Kerr
 Gross Lindsay

Frank Rasche
 Steven Riggs
 Arnold Simpson
 David Stengel
 Ernest Fletcher
 Bob Heleringer
 Kathy Hogancamp
 Jon David Reinhardt
 Katie Stine

Labor & Industry

Ron Cyrus — Chair
 Denver Butler — Vice Chair
 Charles Nelson — Vice Chair
 Charles Siler — Vice Chair
 Rocky Adkins
 Mark Brown
 Hubert Collins
 Kelsey Friend, Jr

Joni Jenkins
 Fred Nesler
 Jim Wayne
 Jeffrey Buis
 Donald Farley
 Walter Gee
 Stephen Nunn
 James Zimmerman

Rules

Jody Richards — Chair
 Michael Bowling
 Mark Brown
 Jim Callahan

Larry Clark
 Jack Coleman
 Charles Geveden
 Porter Hatcher, Jr

Thomas Kerr
Jimmie Lee
Jim Maggard
Kenny Rapier
Steven Riggs

John Stacy
Greg Stumbo
Stanton Cave
Danny Ford
Charles Walton

State Government

Ramsey Morris — Chair
Eddie Ballard — Vice Chair
James Bruce — Vice Chair
Ray Mullinix — Vice Chair
Joe Barrows
Jim Callahan
Larry Clark
Charles Geveden
Jimmie Lee
Kenny Rapier

John Stacy
Jim Wayne
Peter Worthington
Thomas Jensen
Paul Marcotte
Lonnie Napier
Jon David Reinhardt
Tommy Todd
James Zimmerman

Transportation

Hubert Collins — Chair
Joni Jenkins — Vice Chair
Fred Nesler — Vice Chair
Michael Bowling
Denver Butler
Freed Curd
Ron Cyrus
Richard Fox
Kelsey Friend, Jr
Jimmie Lee
Jim Maggard

Paul Mason
Donnie Newsome
Pete Worthington
Ray Altman
Barbara Colter
Elbert Hampton
Kathy Hogancamp
Paul Marcotte
Clarence Noland
Richard Sanders, Jr
Charles Siler

NOTE: The above-listed committees are those to which health and medical issues are generally referred.

"The credit in life does not go to the critic who stands on the sideline and points out where the strong stumble, but rather, the real credit in life goes to the man who is actually in the arena, whose face may get marred by sweat and dust, who knows great enthusiasm and great devotion and learns to spend himself in a worthy cause, who, at best if he wins, knows the thrill of high achievement and if he fails, at least fails while daring greatly, so that in life his place will never be with those very cold and timid souls who know neither victory nor defeat."

— THEODORE ROOSEVELT

KENTUCKY HOUSE OF REPRESENTATIVES

Jon W. Ackerson R-47

424 S. 5th Street, Suite 200

Louisville, KY 40202-2304

(502) 587-8111 (H)

(502) 244-0032 (O)

Jefferson

Profession: Attorney

Education: U of L, BA; Indiana U,
JD

Committee Assignments:

Elections & Constitutional

Amendments, Banking &

Insurance, Business Organizations & Professions



H
O
U
S
E

Royce W. Adams D-61

580 Bannister Road

Dry Ridge, KY 41035

(606) 824-3387 (H)

(606) 428-1039 (O)

Carroll, Grant, Harrison, Owen,
Pendleton

Profession: Horse Farmer

Committee Assignments:

Agriculture & Small Business,

Appropriations & Revenue

**Rocky Adkins D-99**

PO Box 688

Sandy Hook, KY 41171

(606) 928-6644 (H)

(606) 738-4242 (O)

Boyd, Elliott, Lawrence

Profession: Coal Executive

Education: Morehead State U, BS,
MA

Committee Assignments:

Appropriations & Revenue,

Labor & Industry



Willard C. Allen R-17

3750 Gilstrap Road
Morgantown, KY 42261
(502) 526-5149 (H)
Butler, Grayson, Ohio
Profession: Farmer
Education: Murray State U, BS
Committee Assignments: Business
Organizations & Professions



Ray H. Altman R-51

PO Box 4009
Campbellsville, KY 42718
(502) 465-4218 (H)
(502) 465-7889 (O)
Green, Metcalfe, Taylor
Profession: Insurance Agent
Education: U of Alabama
Committee Assignments:
Appropriations & Revenue,
Banking & Insurance,
Transportation



John A. Arnold Jr D-7

1301 North Lee
Sturgis, KY 42459
(502) 333-4641 (H)
(502) 333-5763 (O)
Daviess, Henderson, Union
Profession: Chiropractor
Committee Assignments: Business
Organizations & Professions



Adrian K. Arnold D-74

3589 Aarons Run Road
Mt Sterling, KY 40353
(606) 498-3034 (H)
Bath, Menifee, Montgomery,
Powell
Profession: Farmer
Education: Morehead State U
Committee Assignments:



Joseph Eddie Ballard D-10

PO Box 36

Madisonville, KY 42431

(502) 821-4767 (H)

(502) 821-6255 (O)

Hopkins

Profession: Businessman

Committee Assignments:

Banking & Insurance, State
Government



Joseph Howard Barrows D-56

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(606) 873-4911 (H)

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Franklin, Jessamine, Woodford

Profession: Attorney

Education: DePauw U, BA;

U of K, JD

Committee Assignments:

Appropriations & Revenue, State
Government



Sheldon E. Baugh R-16

252 West Valley

Russellville, KY 42276

(502) 726-7616 (H)

(502) 726-2712 (O)

Logan, Todd

Profession: Insurance Agency
Owner

Committee Assignments:

Banking & Insurance



H
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Kaye Bondurant D-26

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Bullitt, Hardin, LaRue

Profession: Businesswoman

Committee Assignments:



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Bell, Harlan, Leslie

Profession: Attorney

Education: U of K, BA; Chase

College of Law, JD

Committee Assignments: Judiciary,
Rules, Transportation



Lawrence W. Brandstetter R-79

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Fayette

Profession: Architect

Education: Ohio State U, BS

Committee Assignments: Economic
Development



Mark S. Brown D-27

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(502) 422-4225 (O)

Bullitt, Hardin, Meade

Profession: Pipefitter, Mechanical
Technician

Education: Western KY U

Committee Assignments:
Appropriations & Revenue,
Labor & Industry, Rules



James E. Bruce D-9

6750 Ft Campbell Boulevard

Hopkinsville, KY 42240

(502) 886-2422 (H)

Christian, Hopkins

Profession: Farmer

Education: U of Tennessee, BS

Committee Assignments:
Banking & Insurance, State
Government



Jeffrey Buis R-52

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Casey, Russell, Wayne

Profession: Printer

Education: U of K

Committee Assignments:

Agriculture & Small Business,

Judiciary, Labor & Industry

**Thomas J. Burch D-30**

4012 Lambert Avenue

Louisville, KY 40218

(502) 583-0569 (H)

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Jefferson

Profession: Production Manager

Education: Bellarmine College, BA

Committee Assignments: Business

Organizations & Professions,

Health & Welfare

**Dwight D. Butler R-18**

PO Box 194

Harned, KY 40143

(502) 756-5931 (H)

Breckinridge, Hancock, Hardin,
Meade

Profession: Auctioneer, Farmer

Education: Eastern KY U, BBA

Committee Assignments:

Agriculture & Small Business,

Economic Development

**Denver Butler D-38**

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Jefferson

Profession: Meat Cutter

Education: Jefferson Community
College

Committee Assignments: Business

Organizations & Professions,

Labor & Industry, Transportation

**H
O
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E**

James P. Callahan D-67

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Southgate, KY 41017

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Campbell, Kenton

Profession: Office Manager

Education: Thomas More College

Committee Assignments:

Appropriations & Revenue,

Rules, State Government



Stanton L. Cave R-45

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Fayette

Profession: Attorney

Education: U of K, BS, JD

Committee Assignments:

Banking & Insurance, Judiciary,

Rules



Perry B. Clark D-37

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Jefferson

Profession: Quality Training

Committee Assignments:

Elections & Constitutional

Amendments, Health & Welfare,

Labor & Industry



Larry D. Clark D-46

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Jefferson

Profession: Electrician

Committee Assignments:

Appropriations & Revenue,

Business Organizations &

Professions, Rules, State

Government



Philip Joseph Clarke D-54

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Boyle, Lincoln
Profession: Attorney
Education: Notre Dame U, BSCE;
Georgetown U, JD
Committee Assignments:
Elections & Constitutional
Amendments, State Government



Jack L. Coleman Jr D-55

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Burgin, KY 40310
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Anderson, Mercer, Spencer
Profession: Lumber Yard Owner
Education: Eastern KY U
Committee Assignments:
Agriculture & Small Business,
Economic Development, Rules



Hubert Collins D-97

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Wittensville, KY 41274
(606) 297-3152 (H)
Johnson, Magoffin, Martin
Profession: Teacher, Car Dealer,
Realtor
Education: Morehead State U, BA,
MA
Committee Assignments: Labor &
Industry, Transportation



Barbara W. Colter R-90

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Manchester, KY 40962
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(606) 598-2833 (O)
Clay, Leslie, Perry
Profession: Educational Supervisor,
Store Owner
Education: Cumberland College,
BS; Union College, MA
Committee Assignments:
Transportation



Brian J. Crall R-13

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Owensboro, KY 42303
(502) 926-9622 (H)
(502) 683-8011 (O)

Daviess

Profession: YMCA Executive

Education: Rock Valley College,
AA; Murray State U, BS

Committee Assignments:

Banking & Insurance, Economic
Development, Judiciary, Rules



Jesse Crenshaw D-77

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Lexington, KY 40507
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Fayette

Profession: Attorney

Education: KY State, BA;
U of K, JD

Committee Assignments: Health &
Welfare, Judiciary



Freed Curd D-5

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Murray, KY 42071
(502) 753-9378 (H)
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Calloway, Trigg

Profession: Teacher

Education: Murray State U,
BS, MA

Committee Assignments:

Elections & Constitutional
Amendments, Transportation



Ronald R. Cyrus D-98

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Flatwoods, KY 41139
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(606) 836-8644 (O)

Greenup

Profession: Executive Secretary-
Treasurer, KY AFL-CIO

Education: Ashland Community
College, AA; U of K

Committee Assignments: Economic
Development, Labor & Industry,
Transportation



Robert R. Damron D-39

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Nicholasville, KY 40356

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Garrard, Jessamine, Lincoln

Profession: Insurance Agent

Education: U of K, BS, MDA

Committee Assignments: Business

Organizations & Professions,

Health & Welfare



Herbert Deskins Jr D-94

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Pikeville, KY 41501

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(606) 432-3414 (O)

Martin, Pike

Profession: Attorney

Education: U of K, JD

Committee Assignments:

Banking & Insurance, Judiciary



HOUSE

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Jefferson

Profession: Physician

Education: U of K, BS; U of L, MD

Committee Assignments: Health &

Welfare



Donald B. Farley R-100

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Ashland, KY 41101

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Boyd

Profession: Realtor

Education: Eastern KY U;

Marshall U

Committee Assignments:

Appropriations & Revenue,

Labor & Industry



Mark Farrow D-62

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(502) 535-6104 (O)
Harrison, Scott
Profession: Attorney
Education: Georgetown College;
KY State U, BA; Chase College
of Law, JD
Committee Assignments:
Agriculture & Small Business,
Banking & Insurance



Ernest L. Fletcher, MD, R-78

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Fayette
Profession: Physician
Education: U of K, BS, MD
Committee Assignments: Business
Organizations & Professions,
Health & Welfare, Judiciary



Danny R. Ford R-80

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McCreary, Pulaski, Rockcastle,
Wayne
Profession: Auctioneer & Realtor
Education: Eastern KY U, BS
Committee Assignments:
Appropriations & Revenue, Rules



Rick Fox D-88

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Harlan
Profession: Financial Consultant
Education: Morehead State U, BA
Committee Assignments:
Transportation



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Pike

Profession: Attorney

Education: U of K, JD

Committee Assignments: Judiciary,
Labor & Industry, State
Government, Transportation



Walter Gee R-96

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Grayson, KY 41143

(606) 474-5489 (H)

Carter, Lewis

Profession: Store Owner

Education: KY School of
Embalming

Committee Assignments:
Agriculture & Small Business,
Labor & Industry



Charles R. Geveden D-1

PO Box 518

Wickliffe, KY 42087

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(502) 335-3683 (O)

Ballard, Carlisle, Fulton, Hickman,
McCracken

Profession: Attorney

Education: Vanderbilt U, BA;
U of L, JD

Committee Assignments:
Appropriations & Revenue,
Judiciary, Rules, State
Government



Jim Gooch Jr D-12

210 Bradley Street

Providence, KY 42450

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(502) 667-7327 (O)

Caldwell, Hopkins, McLean,
Webster

Profession: Insurance Agent

Committee Assignments: Health &
Welfare



H. G. "Gippy" Graham D-57

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Frankfort, KY 40601

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Franklin

Profession: Educator

Education: Cumberland College,

AA; Georgetown College, BA;

U of K, MA

Committee Assignments:

Appropriations & Revenue,

Transportation



Drew Graham D-73

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Clark, Powell

Profession: Farmer &

Agribusinessman

Education: U of K, BS, MA

Committee Assignments:



J. R. Gray D-6

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Benton, KY 42025

(502) 527-8376 (H)

Caldwell, Lyon, Marshall

Profession: Consultant

Education: American School,

Chicago

Committee Assignments: Business

Organizations & Professions,

Economic Development &

Natural Resources



Elbert Reed Hampton R-86

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Artemus, KY 40903

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(606) 546-3292 (O)

Knox, Laurel

Profession: Plant Superintendent

Committee Assignments:

Banking & Insurance



E. Porter Hatcher Jr D-43

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(502) 778-9051 (O)

Jefferson

Profession: Insurance Agent &
Realtor

Education: U of L

Committee Assignments:

Appropriations & Revenue,
Banking & Insurance, Business
Organizations & Professions, Rules



Bob Heleringer R-33

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(502) 584-8111 (H)

(502) 245-7173 (O)

Jefferson

Profession: Attorney

Education: Xavier U, BA; U of L,
JD

Committee Assignments:

Appropriations & Revenue,
Health & Welfare, Judiciary



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Kathy Hogancamp R-4

300 Acorn

Paducah, KY 42003

(502) 554-8709 (H)

Crittenden, Livingston, McCracken

Profession: Tutor

Education: Murray State U, BS;
SIU Carbondale, MS

Committee Assignments: Economic
Development, Judiciary,
Transportation



Joni L. Jenkins D-44

3516 Mildred, No. 2

Shively, KY 40216

(502) 361-1389 (H)

Jefferson

Profession: Communications
Specialist

Education: U of K, BA

Committee Assignments: Labor &
Industry, Transportation



Tom Jensen R-85

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London, KY 40741

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(606) 864-9772 (O)

Laurel

Profession: Attorney

Education: Sue Bennett College;

Cumberland College, BS; Chase

College of Law, JD

Committee Assignments:

Elections & Constitutional

Amendments, State Government

**Thomas Robert Kerr D-64**

5415 Old Taylor Mill Road

Taylor Mill, KY 41015

(606) 431-2222 (H)

(606) 356-1344 (O)

Kenton

Profession: Attorney

Education: U of K, BBA; Chase

College of Law, JD

Committee Assignments:

**Jimmie Lee D-25**

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Elizabethtown, KY 42071

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(502) 737-8889 (O)

Hardin

Profession: Auto Sales

Committee Assignments:

Appropriations & Revenue,

Rules, State Government,

Transportation

**Bill Lile R-28**

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Valley Station, KY 40272

(502) 583-0569 (H)

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Jefferson

Profession: Teacher

Education: U of K, BA;

Western KY U, MA

Committee Assignments: Business

Organizations & Professions



Gross C. Lindsay D-11

PO Box 19

Henderson, KY 42420

(502) 827-9824 (H)

(502) 827-1310 (O)

Henderson

Profession: Attorney

Education: U of K, BA, JD

Committee Assignments: Economic
Development, Elections &
Constitutional Amendments



Marshall Long D-58

PO Box 505

Shelbyville, KY 40065

(502) 633-3181 (H)

(502) 633-3621 (O)

Henry, Shelby, Trimble

Profession: Businessman

Education: Centre College, BA

Committee Assignments:
Appropriations & Revenue,
Banking & Insurance, Economic
Development



HOUSE

Jim Lovell D-72

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Paris, KY 40361

(606) 987-2747 (H)

Judiciary

Profession: Attorney

Education: U of K, JD

Committee Assignments: Judiciary



Jim Maggard D-89

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Jackson, KY 41339

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(606) 666-4495 (O)

Breathitt, Magoffin, Perry, Wolfe

Profession: Public Relations

Education: Career School of
Broadcasting

Committee Assignments: Economic
Development, Rules,
Transportation



Paul H. Marcotte R-60

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Union, KY 41091
(606) 781-3800 (H)
(606) 384-1097 (O)
Boone, Gallatin
Profession: Business Executive
Education: St. John's U, BA
Committee Assignments: Business
Organizations & Professions,
State Government,
Transportation



Allen Maricle R-49

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Pioneer Village, KY 40229
(502) 955-7584 (H)
Bullitt
Profession: Communications
Specialist
Education: Sullivan Junior College
Committee Assignments: Business
Organizations & Professions,
Elections & Constitutional
Amendments



Mary Lou Marzian D-34

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(502) 451-5032 (O)
Jefferson
Profession: Registered Nurse
Education: U of L, BS
Committee Assignments: Economic
Development & Natural
Resources, Elections &
Constitutional Amendments,
Health & Welfare



Paul Mason D-91

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Whitesburg, KY 41858
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(606) 633-0415 (O)
Letcher, Perry
Profession: Automobile Dealer
Education: Alice Lloyd College,
AA; U of L; Pikeville College
Committee Assignments:
Appropriations & Revenue,
Health & Welfare,
Transportation



Harry Moberly Jr D-81

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Richmond, KY 40475

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Madison

Profession: Attorney

Education: Eastern KY U, BA;

U of L, JD

Committee Assignments:

Appropriations & Revenue



H. Ramsey Morris Jr D-8

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Hopkinsville, KY 42240

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(502) 885-4029 (O)

Christian, Trigg

Profession: Businessman

Committee Assignments:

Banking & Insurance, Health &
Welfare, State Government



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Ray Mullinix R-53

208 Baker Street

Burkesville, KY 42717

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(502) 864-3881 (O)

Adair, Clinton, Cumberland,
Wayne

Profession: Broadcaster

Education: Lindsey Wilson College

Committee Assignments:

Agriculture & Small Business,
State Government



Richard L. Murgatroyd R-63

2927 Prospect Point Drive

Villa Hills, KY 41017

(606) 261-7916 (H)

(606) 341-3379 (O)

Kenton

Profession: Tour Company
Manager

Education: Ohio State U, BA, MA

Committee Assignments: Economic
Development



Lonnie Napier R-36

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Lancaster, KY 40444

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Garrard, Jackson, Lincoln,
Madison, Pulaski

Profession: Auctioneer, Realtor,
Farmer

Committee Assignments:

Appropriations & Revenue,
Economic Development, State
Government



Charles Nelson D-15

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Bremen, KY 42325

(502) 525-3464 (H)

McLean, Muhlenberg

Profession: Miner

Committee Assignments: Labor &
Industry



Fred Nesler D-2

PO Box 323

Mayfield, KY 42066

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Graves, McCracken

Profession: Realtor

Committee Assignments: Economic
Development, Labor & Industry,
Transportation



Donnie Newsome D-92

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Dema, KY 41859

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Floyd, Knott, Letcher, Perry

Profession: Store Owner

Committee Assignments: Health &
Welfare, Transportation



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Estill, Jackson, Lee, Owsley

Profession: RR Engineer

Committee Assignments:

Appropriations & Revenue,
Transportation



Anne Meagher Northup R-32

3340 Lexington Road

Louisville, KY 40206

(502) 897-3061 (H)

Jefferson

Profession: Legislator

Education: St Marys of Notre
Dame, BA

Committee Assignments:

Appropriations & Revenue,
Economic Development



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Stephen R. Nunn R-23

121 East Main Street

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(502) 651-6911 (H)

(502) 423-2000 (O)

Barren, Metcalfe

Profession: Insurance Agent

Education: Transylvania U, BA;
U of L School of Law

Committee Assignments: Health &
Welfare, Labor & Industry



Ruth Ann Palumbo D-76

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Fayette

Profession: Legislator/Community
Volunteer

Education: U of K, BA

Committee Assignments:

Appropriations & Revenue,
Business Organizations &
Professions, Health & Welfare



Kenny Rapier D-50

115 Parkview Drive
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(502) 348-3596 (O)
Nelson, Spencer, Washington
Profession: Self-Employed
Education: Bellarmine College, BA
Committee Assignments:
Appropriations & Revenue,
Rules, State Government



Frank Rasche D-3

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(502) 443-5167 (H)
(502) 443-5521 (O)
McCracken
Profession: Businessman
Education: Vanderbilt U, BA;
Murray State U, MA
Committee Assignments:
Banking & Insurance, Judiciary



Jon David Reinhardt R-69

637 W. Poplar Thicket Road
Alexandria, KY 41001
(513) 397-6303 (H)
(606) 635-3455 (O)
Boone, Campbell, Kenton
Profession: Telephone Company
Manager, Realtor, Businessman
Education: U of K, U of Cincinnati
Committee Assignments: Business
Organizations & Professions,
Judiciary, State Government



Jody Richards D-20

817 Culpeper Street
Bowling Green, KY 42103
(502) 781-9946 (H)
(502) 842-6731 (O)
Warren
Profession: Book Store Owner
Education: KY Wesleyan College,
AB; U of Missouri, MA;
Indiana U
Committee Assignments: Rules



Steven Riggs D-31

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Jefferson

Profession: Insurance Agent

Education: U of K, BBA

Committee Assignments:

Banking & Insurance, Judiciary,
Rules



Tom Riner D-41

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(502) 584-3639 (O)

Jefferson

Profession: Minister

Education: Centre College;

Southern Baptist Theological

Seminary; Heritage Baptist U

Committee Assignments: Economic
Development



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Richard A. Sanders Jr R-19

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Edmonson, Grayson, Hardin,
Warren

Profession: Farmer, Restaurant
Owner

Education: Western KY U

Committee Assignments:

Agriculture & Small Business,
Transportation



Ernesto Scorsone D-75

167 W. Main, No. 804

Lexington, KY 40507

(606) 254-5766 (H)

(606) 254-3781 (O)

Fayette

Profession: Attorney

Education: U of K, BA, JD

Committee Assignments:

Appropriations & Revenue,
Health & Welfare



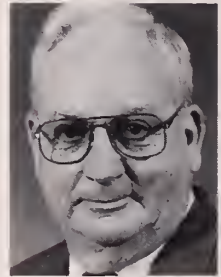
William U. Scott D-24

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Raywick, KY 40060
(502) 692-9229 (H)
Hart, LaRue, Marion, Washington
Profession: Timber Sales
Education: Eastern KY U, BS
Committee Assignments:
Agriculture & Small Business,
Economic Development &
Natural Resources



Charles L. Siler R-82

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McCreary, Whitley
Profession: Farmer
Education: U of Wisconsin, MA
Committee Assignments: Labor &
Industry, Transportation



Arnold Simpson D-65

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(606) 581-6521 (O)
Kenton
Profession: Attorney
Education: KY State U, BA;
U of K, JD
Committee Assignments:
Banking & Insurance, Elections &
Constitutional Amendments,
Judiciary



John Will Stacy D-71

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Magoffin, Menifee, Morgan,
Rowan
Profession: Businessman
Education: Morehead State U, BS;
Chase College of Law, JD
Committee Assignments:
Appropriations & Revenue,
Rules, State Government



Dave Stengel D-29

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(502) 239-7432 (O)

Jefferson

Profession: Attorney

Education: U of K, BA; U of L, JD

Committee Assignments:

Banking & Insurance, Judiciary



Katie K. Stine R-68

15 Cliffview

Ft Thomas, KY 41075

(606) 781-5311 (H)

Bracken, Campbell, Pendleton

Profession: Attorney/Homemaker

Education: U of Cincinnati, BS;

Chase College of Law, JD

Committee Assignments: Health &

Welfare, Judiciary



HOUSE

Gregory D. Stumbo D-95

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(606) 886-9953 (O)

Floyd, Martin

Profession: Attorney

Education: U of K, BA; U of L, JD

Committee Assignments: Rules



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Pulaski

Profession: Building Contractor

Committee Assignments:

Appropriations & Revenue,

Health & Welfare, State

Government



Mark A. Treesh R-14

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Philpot, KY 42366

(502) 686-4311 (H)

(502) 729-9202 (O)

Daviess

Profession: College Professor

Education: Purdue U, BS, MS

Committee Assignments:

Appropriations & Revenue,

Banking & Insurance



Richard A. Turner R-22

1292 Early Burkes Road

Tompkinsville, KY 42167

(502) 427-4233 (H)

Allen, Monroe, Simpson

Profession: Farmer & Merchant

Education: Western KY U, AB

Committee Assignments:

Agriculture & Small Business,

Appropriations & Revenue



Charlie Walton R-66

1663 Brierwood Court

Florence, KY 41042

(606) 371-1943 (H)

Boone, Kenton

Profession: Teacher

Education: Eastern KY U, BS;

Northern KY U, MA

Committee Assignments: Rules



Jim Wayne D-35

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KMA HOUSE OF DELEGATES

POLICY ON

LEGISLATIVE ACTIVITIES

- All state legislative proposals are to be coordinated by and channeled through the Committee on State Legislative Activities.
- The composition, authority, and function of the Quick Action Committee are to be retained.
- The composition, priority, manner, and time of introduction of state legislative proposals are to be left to the discretion of the Chairman of the Committee on State Legislative Activities and the Quick Action Committee.

While KMA staff is in Frankfort for the Kentucky General Assembly, they are responsible only to their immediate superiors and not to individual members of the Association. Any complaint relative to the state legislative program or its operation should be directed to the State Legislative Committee Chairman and not to staff.



"The science of legislation is like that of medicine in one respect; viz.: that it is far more easy to point out what will do harm, than what will do good."

— COLTON

LEGISLATIVE TERMS AND DEFINITIONS

The following terminology may be helpful to you in your involvement with legislative process.

Acts — the volume of bills enacted at one session; published by Legislative Research Commission

Adjourn (motion to) — an action to discontinue proceedings for the day; a privileged motion non-debatable, not subject to amendment, and requiring for its adoption the assenting votes of a majority of the members present and voting

Adjournment Sine Die — adjournment “without a day”; this action ends a session, since no time is set for reconvening; this type of adjournment may occur at any time during a session

Administrative regulation — an enactment of law by an executive-branch agency or department, under authority granted by the General Assembly

Administration bill — legislation introduced at the behest of an executive-branch agency or department, usually sponsored by the majority floor leader

Adoption — approval or acceptance; usually applied to resolutions or amendments

Amend (motion to) — an action to modify the contents of a bill or question under consideration; the motion to amend is in order at any time prior to final passage, unless the previous question has been ordered

Amendment — any alteration made or proposed to be made in a bill, motion or clause thereof, by adding, substituting or deleting

Committee — a group of legislators, usually members of the same house, assigned to consider some issue or question and submit a report on its recommendations for action by the body which created it

Committee amendment — an amendment to a bill which is attached to the bill by a committee and made a part of the committee’s report on the bill

Conference Committee — a joint committee of senators and representatives directed to reach agreement on legislation on which the two houses are unable to agree

Committee, interim joint — a committee composed of all members of a Senate standing committee and all members of a House standing committee, which meets between sessions as a subcommittee of the Legislative Research Commission

Committee substitute — a bill offered by a committee in lieu of a bill it has considered; technically, the committee substitute is an amendment to the original bill

Companion bill — a bill which is identical to a bill having been introduced in the opposite house

Concur — action by one house to agree to modifications of its legislation by the opposite house

Consent calendar (or consent orders) — a list of bills having had one (or two) reading(s), and on which members in attendance are presumed to vote yes unless they indicate a

negative vote prior to the call of the roll

Constitutional majority — one more than half of the members of deliberative body

Co-sponsor — a sponsor of a bill or resolution who is not the principal sponsor

Effective date — the date on which a legislative measure begins to function as a part of the law; in Kentucky, most legislation becomes effective 90 days after sine die adjournment

Emergency clause — provision in a bill that it become effective immediately upon approval by the governor rather than the 90 days after adjournment

Enrollment — the act of comparing a printed bill to be transmitted to the governor with the original; introduced bill with all amendments, so as to ascertain their identical form

Floor — the area of a legislative chamber which is occupied by the members and staff of the body

Floor amendment — an amendment filed with the clerk to be considered on third reading of the bill to which it has been filed

General orders — a list of measures eligible for debate, amendment and voting on a given day, without reference to a particular time of day or place in the order of business

Hopper — colloquial name given the repository for bills awaiting introduction; in Kentucky such bills are filed with the clerk

House — one body of deliberation in a legislature; customarily a shortened name for the House of Representatives

Interim — the period of time between sessions of a legislature

Introduction — the presentation of a bill or resolution to the legislative body for its consideration

Joint sponsorship — a procedure in the Kentucky House of Representatives whereby several members may sponsor legislation without one being a "principal" sponsor, and each bearing equal responsibility as endorsing the measure

Kentucky Revised Statutes — the official title of statute law in Kentucky; each bill creates, amends, or repeals a section of the **KRS**

Lay on the clerk's desk (motion to) — an action to place a measure in a position of temporary postponement

Lay on the table (motion to) — an action to declare a measure defeated

Majority caucus chairman — a member affiliated with the majority party, who is responsible for convening the caucus of his party and presiding over its deliberations

Majority floor leader — a member affiliated with the majority party, designated to act for the party during the proceedings on the floor

Majority party — the political party whose members occupy at least one more than half of the total membership of the body

Majority whip — a member affiliated with the majority party, designated to assist the floor leader during proceedings on the floor

Passage — the approval of a bill or resolution by way of an affirmative vote

Postpone indefinitely (motion to) — action to prevent consideration of a measure for the remainder of the session, unless a constitutional majority sustains a motion to reconsider the matter

Postpone a fixed time (motion to) — to defer consideration

- of a question until a time specified in the motion
- Prefiled bill** — a bill filed prior to the session, for public discussion and printing
- President** — the presiding officer in the Senate
- President pro tempore** — the Senator, elected by the Senate, chosen to preside in lieu of the President when such officer is absent or unable to preside
- Quorum** — the number of members of a legislative body which must be present to transact business
- Reading** — each bill to be enacted in Kentucky must have three readings, at length, in each house
- Recommit (motion to)** — action to send a measure to committee after it has been previously reported
- Reconsider (motion to)** — action to re-take a vote; the motion may be offered only by a member having voted previously on the prevailing side
- Refer** — to send a measure or question to committee
- Resolution, concurrent** — expression of opinion or request by both houses of a legislature, without the force of law
- Resolution, joint** — to enact matters of law not to be made a portion of the statutes
- Resolution, simple** — expression or request by one house
- Revision** — the process of inserting the enactments of a session into existing statute law
- Roll call** — to determine a vote on a question by taking of names in favor and opposed
- Section** — a division of a bill or statute, separated according to topic covered or action taken
- Session, extraordinary** — a session convened by call of the Governor
- Session, regular** — a session convened on a regular basis by way of constitutional provision as to its date and length
- Simple majority** — a majority of those voting on a question
- Speaker** — the presiding officer of the House of Representatives
- Speaker pro tempore** — the member of the House of Representatives selected to preside in the absence or inability of the Speaker
- Special order** — an action predetermined to occur at a specific time on a specific date
- Stopping the clock** — an occasional tactic on the final evening of a regular session whereby the proceedings continue into the following day, with the clock and journal continuing to indicate occurrences of action of the preceding day
- Sunset legislation** — a law requiring termination of a particular agency or program on a predetermined date, unless justification for continuance is presented to the legislature prior to such occurrence
- Suspend the rules** — action to negate the application of a particular rule of procedure; the rule and purpose must be stated in the motion to suspend
- Veto** — rejection of an enactment without authority to modify; usually the prerogative of the Governor
- Veto override** — authority of the legislature to overturn a rejection of legislation by the Governor
- Voice vote** — a method of voting whereby only a vocal response to a question is indicated
- Vote** — a decision on a question by a member of a deliberative body, either affirmative or negative
- Withdraw** — to recall, remove or delete a question from consideration

MEDICAID

Historically, Medicaid payments to physicians have been lower than other third party payors. Rates were based on an arcane formula that often produced fees that barely covered costs. Regardless, KMA understood the limitations of Kentucky's budget and accepted payment rates as they were developed by the state. KMA did not actively lobby the budget making process. We realized that more and more services were being mandated by the federal government, that the universe of people eligible for the program was constantly expanding, and that long term care for the elderly was becoming an increasingly difficult problem.

Medicaid physician payment rates remained essentially unchanged from 1978 through 1988. There was a small increase in 1989 for obstetrical and pediatric care driven by the federal Boren Amendment. On July 1, 1990, there was a slight overall increase for all other physicians.

During the 1991 Special Session, HB 21 instituted a tax on, among others, "fee for service" providers. As HB 21 became law in Kentucky, Medicaid payment rates changed and physicians realized a substantial increase in their payment rates. Physicians also paid a 15% tax on revenues generated from the Medicaid program. At the same time Kentucky, and the Medicaid program specifically, profited from the provider tax. For every \$4.00 raised, Medicaid kept \$2.00 and this occurred without use of general fund dollars.

In 1991 physicians began to see new tax dollars flowing into the Medicaid program. Half of those dollars, right off the top, went to help the program generally. Other monies brought to a reasonable level, rates that had not been updated for ten years. This made participation in the Medicaid program more attractive to physicians and enhanced access to care for Medicaid eligible patients.

A Special Session of the General Assembly in May 1993, enacted HB 1, which levied a 2% tax on physician services. Physicians were prohibited from passing on this tax to the recipient of the health care services. The express purpose of this tax was to help fund the Medicaid program, which was described by the Administration as "nearly bankrupt." In the summer of 1993, shortly after the tax was enacted, Medicaid announced a \$139 million budget surplus. Despite this surplus, physician reim-

bursement did not increase nor was implementation of the tax halted.

The 1994 General Assembly included a 2% provider tax as part of HB 250, Kentucky's so-called health systems reform measure. This tax was sold to physicians as the only alternative to keep Medicaid solvent and reimbursement at a reasonable level. Shortly after this tax was enacted, physician Medicaid reimbursement was slashed some \$52 million. Despite a legal challenge, these cuts remain in effect.

Kentucky physicians receive approximately 12 cents of the Medicaid dollar, compared to 19 cents of the health care dollar spent nationally. Despite Medicaid's historically low reimbursement rate and the provider tax, KMA has consistently urged physicians to participate in the program and treat patients regardless of their ability to pay. The Association has been the cornerstone of the Kentucky Physicians Care Program which has referred over 55,000 patients to physicians who have treated them without charge. Over 60% of KMA members participate in the KPC program with over 250,000 physician/patient encounters.

Kentucky physicians have made a strong and positive contribution to caring for Kentucky's poor. Our activities with respect to Medicaid and the Kentucky Physicians Care Program attest to that.

Medicaid Facts

- Most physicians receive less than \$5,000 per yr (59.9%)
- Nearly 70% receive less than \$10,000 per year
- Many physicians receive \$25.00 or less per patient
- Drs rank 24th of 44 providers in average pay per patient
- Physicians are paid less than transportation providers
- Physicians receive only 14% of Medicaid expenditures
- Physicians treated 2,110,559 Medicaid patients in 1994
- High usage = misleading "total physician payment" figure
- % of Drs with large Medicaid practices is minuscule
- Only 208 (3.5%) received \$100,000 or more in FY 1994

PROVIDER TAX

Between 1991 and 1993, Kentucky obtained a portion of funding for its Medicaid program through a tax on physicians. This taxing mechanism was known as HB 21. This tax was imposed only on physicians voluntarily participating in the Medicaid program, and was equal in amount to one-half ($\frac{1}{2}$) of the increase in revenues realized by the participating physician as a result of the July 1, 1991, Medicaid fee update (not to exceed 15% of the physician's gross Medicaid revenue for each calendar quarter). The Kentucky law further provided that any Medicaid participating physician would be reimbursed for the entire amount of the tax from the Medicaid fund. Thus, the physicians and other health care providers serving Medicaid patients were held harmless for the tax.

Under a 1991 amendment to federal law, the amount of state expenditures recognized by the federal government for purposes of determining matching funds was reduced by the amount of any health care related tax found to be impermissible under the amendment. Under this amendment, a state health care related tax is permissible if it is broad based, uniformly imposed, and does not hold the state health care taxpayers harmless for their tax costs.

Kentucky's tax on health care professionals, as it existed under the HB 21 taxing mechanism, constituted an impermissible state tax for purposes of the 1991 amendment since it purported to hold taxpayers harmless for the tax. The effect of this impermissibility was to risk that portion of Kentucky's Medicaid expenditures based on the tax on health care professionals (including physicians) participating in Medicaid. Any impermissible tax receipts would be disregarded by the federal program, which in turn would mean a reduced level of matching funds to fund Kentucky's Medicaid program.

The intent of the 1993 Special Session of the General Assembly in enacting HB 1 was to impose a tax on health care providers in a manner consistent with the 1991 amendment to federal law, in order to maintain the state's level of Medicaid expenditures so as not to suffer a reduction in the level of federal matching funds.

HB 1 imposed a 2% tax on the gross revenues of providers of physician services, nursing facility services, intermediate care facility services for the mentally retarded, home health care services, and health mainte-

nance organization services. Physicians were specifically prohibited from passing this tax on to the recipient of the health care services.

Prior to the implementation of HB 1 on July 1, 1993, the KMA Board of Trustees voted to mount a legal challenge to the constitutionality of this law. This tax was ultimately determined to be constitutional by the state and federal courts.

The Kentucky General Assembly, during its 1994 Regular Session, included a provider tax provision in HB 250. This tax replaced the HB 1 version of the provider tax on July 15, 1994. This provider tax is imposed on physicians at a rate of 2% on gross revenues. "Gross revenues" is defined as a total amount received in money or otherwise by a provider for the provision of health care items or services in Kentucky, less certain exemptions.

Conspicuous by its absence in the HB 250 version of the provider tax is a prohibition on passing the tax on to the recipient of the service or any third party. For all practical purposes, this silence has been interpreted to mean that physicians cannot pass the tax on to the recipient of health care services.

KMA has always opposed a provider tax. Reliance on such a mechanism as a long-term, stable source of funding for an ever-expanding Medicaid program is not logical. Kentucky physicians already subsidize a substantial portion of the cost of health care for the indigent. Physicians routinely treat not only Medicaid patients, but also patients who have no insurance, and they will continue to do so regardless of the patient's ability to pay. Physicians stand ready to contribute their "fair share," but to shoulder the entire burden is unfair.

Provider Tax Facts

- Physicians pay 24% of amount collected through tax
- Physicians receive only 14% of Medicaid expenditures
- Assessment exceeds 4% of most physicians Net Income
- Tax paid exceeds fees received for most physicians
- Physicians not in Medicaid program must pay tax
- KY is 1 of only 3 states with provider tax on physicians
- Only KY & W. WA levy tax on gross receipts
- Tax is a negative for physician recruitment

MEDICAL LIABILITY —

A History of Legislation in Kentucky

During the mid-1970s, Kentucky, like many other states, was caught in a medical liability crisis. The market for professional liability coverage began to shrink. If coverage was available, its price was prohibitive.

When the General Assembly convened in 1976, Kentucky legislators were acutely aware of the problem. At KMA's request, a special task force appointed by the Governor studied the situation for months.

Kentucky's General Assembly responded in 1976 by passing legislation which:

• Eliminated the Ad damnum clause • Provided that an advance payment could not be used as evidence to show admission of liability on the part of the physician or the insurance carrier • Adopted the Statute of Frauds, allowing no liability for guarantees unless submitted to the patient in writing • Codified informed consent into law • Ensured the confidentiality of peer review • Established a patient compensation fund, requiring all physicians and hospitals to belong • Created a joint underwriting association for providers to obtain coverage • Required reporting of all claims, settled or adjudicated, to the state Insurance Commissioner.

In 1977, the Kentucky Supreme Court ruled that provisions relating to the creation and maintenance of the Patient's Compensation Fund were unconstitutional. The Court also declared that the amendment establishing peer review confidentiality was unconstitutional because the amendment was not germane to the title of the enacting legislation.

The 1978 General Assembly re-enacted legislation regarding peer review confidentiality.

In 1978, the Kentucky Medical Association founded Kentucky Medical Insurance Company. Today, it insures approximately 50% of Kentucky's practicing physicians.

In 1980, the liability crisis reappeared, and KMA sought legislative relief from the 1986 General Assembly. The KMA supported legislation to limit awards, limit noneconomic awards, reduce statute of limitations for minors, and establish periodic payments. None of the KMA-supported measures were passed.

In 1988, the KMA joined with over 20 professional and business organizations to present legislation to resolve the liability crisis. The legislation included proposals to modify the tort system and strengthen insurance laws and regulations. The reform legislation included the following tort reforms relating to physicians liability claims:

- **Joint and Several Liability**
- **Standards of Conduct for Punitive Damages**
- **Collateral Source Rule**
- **Standards of Conduct for Officers and Directors of For-Profit Corporations and Officers, Directors, and Volunteers of Non-Profit Corporations and Charitable Organizations**
- **Confidentiality of Peer Review Records**
- **Antitrust Immunity for Peer Review and Centralized Reporting of Liability Claims**

KMA LEGISLATIVE GOALS

Tort Reform

KMA supports a Constitutional Amendment to permit the General Assembly to place a limitation on non-economic awards. Section 54 of Kentucky's Constitution states, *"The General Assembly shall have no power to limit the amount to be recovered for injuries resulting in death, or for injuries to person or property."* Amending Kentucky's Constitution requires that the proposed amendment be agreed to by three-fifths of all members of the Kentucky General Assembly. Then such proposed amendment must be submitted to the voters of the State for their ratification or rejection at the next general election for members of the House of Representatives. If the amendment is approved by a majority of the voters, it shall become a part of the Constitution of the Commonwealth and be so proclaimed by the Governor. No more than four amendments shall be voted upon at any one time, and each proposed amendment shall be placed on the ballot in such manner that the electors shall be allowed to vote on each of such amendments separately. The approval of the Governor shall not be necessary to any proposed amendment to the Constitution.

In a November 1995 statewide survey by Marketing Research Institute, almost two-thirds of Kentucky voters favor limiting non-economic damages in civil lawsuits. Only 27% are opposed. Support for limiting non-economic damages increased from 60% in 1989 to 66% in 1995. The survey was commissioned by Kentucky Forward, a business supported political research organization in Frankfort.

Provider Tax

KMA supports repeal of the physician component of the provider tax.

Discount Option Program

KMA supports repeal of the "provider of last resort" provision (DOP) in HB 250.

Managed Care

Managed care is designed to reduce costs and maintain quality of medical care. A system should be developed to monitor managed care and assure patients' decreased costs, along with quality of medical care.

Medical Records

Medical records are the property of physicians. Copies of records should be available for an appropriate fee. KMA supports repeal of the provision in HB 250 requiring physicians to provide free copies of medical records.

Vehicular Safety

KMA supports the adoption of laws to save lives and reduce medical costs:

- Allowable blood alcohol content (BAC) of Kentucky drivers should be reduced from 0.10 to 0.05.
- All passengers in moving vehicles should be required to use safety belts.
- Periodic testing of vision should be required at the time of driver's license renewal.
- Minors should not be permitted to ride in the rear of open trucks.
- Mandatory motorcycle helmet laws should be retained.
- Addition of lap-shoulder system as standard equipment in rear outboard seating positions.

Indigent Care

KMA recognizes that approximately 400,000 Kentuckians are uninsured. The Association proposes a plan based on Medicaid using the KenPAC approach, which offers basic medical services. Funding for the program may be obtained by taxes from various sources available to the Legislature. The KMA supports additional funding for prenatal and pediatric care.

Nonphysician Practitioners

The KMA opposes licensure of health care workers. Certification of health care personnel should be considered on a case-by-case basis. Enhancement of practice acts by nonphysician practitioners, through legislative fiat rather than through education is inappropriate.

ARNPs and PAs

The KMA supports the joint practice of physicians, physicians assistants (PAs), and Advanced Registered Nurse Practitioners (ARNPs). The KMA endorses legislation to permit PAs and ARNPs to prescribe nonscheduled medication under written protocol and formulary approved by the supervising physician and appropriate licensing authorities. PAs and ARNPs should complete established pharmacological prerequisites and maintain continuing education in the use of prescribed substances in their chosen specialties. There should be well-defined limits

on the number of PAs and ARNPs any physician may supervise within closely defined geographic areas and legislation approving these concepts should establish safeguards prohibiting independent and unsupervised practice.

Health Education

The KMA recommends that health education be taught to all students from kindergarten to 12th grade.

Freedom of Choice

Patients choose their physician on the basis of credentials, experience, reputation, location, interpersonal skills, and other facts. The Kentucky Medical Association strongly supports the patient's freedom of choice of physician and encourages a pluralistic approach to health care delivery that allows patients the option of choosing their own physician, insurance carrier, and health insurance.

Rate Setting

The KMA is opposed to rate setting of physician fees and imposition of global budgets. Historically, rate setting and price controls do not work. Price controls inevitably lead to wage controls, which adversely impact those who can least afford it. Rate setting may lead to rationing of health care, causing diminished quality of care and reduced availability to needed medical procedures. Rate setting would create less access of patients to physicians and medical services and would diminish quality of patient medical care. Rate setting creates more taxpayer-funded government bureaucracy and red tape.

Self Referral

The KMA Judicial Council has endorsed the opinion of the AMA Council on Ethical and Judicial Affairs regarding self referral. The full text of the AMA opinion can be obtained by contacting KMA.

The KMA opposes physicians owning health facilities to which they refer patients, except (a) where the facility was established in response to patient need, ie, where existing facilities were inadequate in number, quality or location in a material way and alternative financing was not available, and (b) where the facility is an extension of the physician's practice, ie, where the physician renders service or supervises the service provided at the facility.

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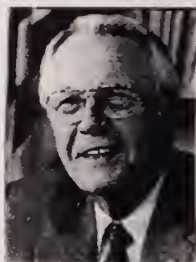
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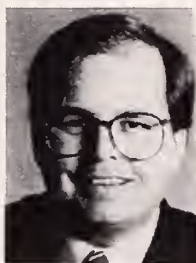
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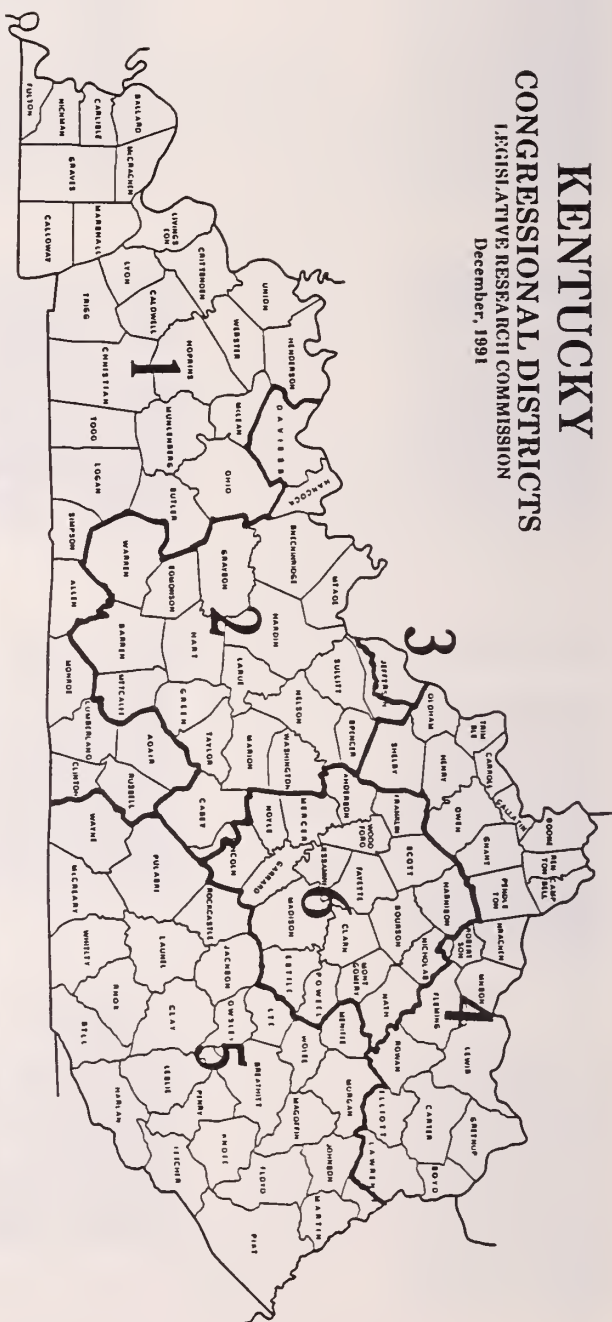
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December, 1991



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Supplement to January 1996

Journal of the Kentucky Medical Association

surgeon, but recurrent attacks of appendicitis are a recognized entity . . .," can seem controversial.

The procedure of diagnostic laparoscopy accompanied by appendectomy has a different relationship to the natural history of abdominal pain than does the procedure of open appendectomy. Radiologic evaluation has not been useful in our hands in defining a group of patients in whom laparoscopy would be of particular benefit. Laparoscopic evaluation with appendectomy is naturally suitable for a variety of patients including those with both acute and chronic complaints, both for evaluation and treatment of their problems. The results of this study suggest that the pathologic status of the appendix cannot be the sole criteria for evaluating the appropriateness of a laparoscopic procedure.

References

1. Pier A, et al. Laparoscopic appendectomy in 625 cases: From innovation to routine. *Surg Lap Endosc.* 1991;1:8-13.
2. Nowzaradan Y. Laparoscopic appendectomy for acute appendicitis. *Surg Lap Endosc.* 1991;5:247-257.
3. Loh A. Laparoscopic Appendectomy. *Br J Surg.* 79:289-290.
4. Timmermans FJ. Laparoscopic appendectomy. *Can J Surg.* 34:542.
5. O'Regan PJ. Laparoscopic appendectomy. *Can. J Surg.* 34(3):256-258.
6. Ragland J, et al. Peritoneoscopy for the diagnosis of acute appendicitis in females of reproductive age. *Surg Endosc.* 1988;1:36-38.
7. Gilchrist BF. Is there a role for laparoscopic appendectomy in pediatric surgery. *J Pediatr Surg.* 27:209-214.
8. Schreiber JH. Early experience with laparoscopic appendectomy in women. *Surg Endosc.* 1991;1:8-13.
9. Saye WB, et al. Laparoscopic appendectomy: Three years' experience. *Surg Lap Endosc.* 1991;2:109-115.
10. Graham A, et al. Laparoscopic evaluation of acute abdominal pain. *J Laparosc Surg.* 1991;3:165-168.
11. Mattei P. Chronic and recurrent appendicitis. *J Amer Coll Surg.* 1994.
12. Seidman JD, et al. Recurrent abdominal pain due to chronic appendiceal disease. *South Med J.* 1991;84:7.
13. Alvarez WC. When should one operate for chronic appendicitis? *JAMA.* 1940;114:1301.
14. Savrin RA, et al. Chronic and recurrent appendicitis. *Am J Surg.* 1979;137:357.
15. Crabbe MM, et al. Recurrent and chronic appendicitis. *SGO* 1986;19(163):11.
16. Lee AW. Recurrent appendiceal colic. *SGO.* 1985;161:21.
17. Ikard RW. Recurrent appendicitis: Awailed disease. *J Tenn Med Assoc.* 1992;105.
18. Homer MJ. Recurrent appendicitis. *Gastrointest Radiol.* 1979;4:295-301.
19. Grossman EB, Jr. Chronic appendicitis. *SGO.* 1978;146(4):596-598.
20. Talbert JL. Appendicitis . . . *Surg Clin North Am.* 1966;46:1101.

Information for Authors

Manuscripts — Articles will be accepted for consideration with the understanding that they are original and are contributed solely to this *Journal*. The transmittal letter should designate one author as correspondent and include the author's address and telephone number. Receipt of manuscripts will be acknowledged and unused manuscripts returned. All material is reviewed by the Board of Editors and publication of any article is not to be deemed an endorsement of the views expressed therein.

Preparation — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.


Copyright assignment — In view of The Copyright Revision Act of 1976, effective January 1, 1978, transmittal letters to the editor must contain the following language and must be signed by all authors: "In consideration of *The Journal of the Kentucky Medical Association* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to *The Journal* in the event that such work is published by *The Journal*."

References — References must be typed in double spacing on separate sheets and numbered consecutively as they are cited. They should include (in this order) the authors' names and initials, title of article (and subtitle if any), abbreviated name of journal, year, volume number, inclusive page numbers. Follow the AMA style currently in use, abbreviating the names of journals in the form given in *Index Medicus*. Authors are responsible for reference accuracy.

Illustrations — Illustrations must be submitted in duplicate and the sequence number and author's name should appear on the back of each. Legends for illustrations should be typewritten (double-spaced) on a separate sheet. The author will be billed for the cost of reproduction of illustrated material for publication in excess of three average illustrations and/or tables. Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source.

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Autonomy

“What we do as physicians is dictated by our own longstanding ethical tradition of providing the best care, of doing no harm, of placing the patient’s interest uppermost in our decision-making.”

Recently, a panel on medical ethics convened to discuss the topic of medical ethics in an era of managed health care. Many aspects of the topic were addressed, but the concept that intrigued me the most was the concept of autonomy. Are there constraints on the autonomy of the patient in a managed care setting? Are there constraints on the autonomy of the physician? How does any limit on autonomy impact the interaction between the doctor and the patient? Ultimately, the panel reached no absolute conclusions, but the discussion was illuminating.

Patient autonomy is, and has been, a relative thing in practice, an absolute thing in theory. The patient’s autonomy to decide a course of medical action has always been limited by the level of medical knowledge they hold, the level of interaction they achieve with their physician (or other health care provider), the availability of services in their geographic vicinity, and the ability to pay for services, among other things. Patients have opted to cede aspects of autonomy to certain individuals or institutions (doctors, family members, insurance companies) with the understanding that they can recover what they have yielded at their own discretion, with the attendant implications (loss of expertise, responsibility for the bill). What seems to be different in the

managed care era is the preeminence and pervasiveness of the economic portion of the equation and the patient’s expectation that participation in a managed care plan insures access to “all care” (although the name “managed care” should be a pretty good tip-off that such expectations are misplaced). Whereas, in the past, patients surrendered economic autonomy to an insurance company which placed no limit on the extent of care received, they now enter relationships which mandate and restrict the care provided. Patients also bring to this discussion a more ingrained sense of entitlement to *any* health care service than in the past (with a less ingrained sense of financial responsibility than in the past in many instances).

In the end, the patient can regain their economic autonomy by opting to pay out of their pocket for the services they desire. This rarely occurs and frequently produces a conflict at the interface of the patient and physician. What we do as physicians is dictated by our own longstanding ethical tradition of providing the best care, of doing no harm, of placing the patient’s interest uppermost in our decision-making. That we continue to do so reaffirms this ethical tradition, even as all around us changes.

Daniel W. Varga, MD
Scientific Editor

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Marla Vieillard

AMA-ERF

Six Good Reasons Why You Should Support The American Medical Association Education and Research Foundation

Making sure the nation's future physicians receive the training they need to maintain the best health care in the world is the first priority for US medical schools. Running a close second is finding ways to finance training as spiraling costs and shrinking dollars combine to make needed sources of funding scarce.

Helping medical schools achieve those goals is the purpose of the American Medical Schools' Education and Research Foundation, which has distributed more than \$65 million to the nation's medical schools in the past 40 years. A major factor in the success of AMA-ERF has been the involvement of the AMAA ALLIANCE members, who raise more than \$2 million each year by urging

physicians and spouses to choose AMA-ERF as their vehicle for supporting medical education. The following are six good reasons why you should be among them.

1. Your gift of \$25, \$50, \$100, or whatever amount is combined with the other gifts of 10, 20, 30, or more donors. This means that the medical schools receive a sizeable amount of money that can make a real difference to their programs.

2. You have the option of designating which school will receive your contribution — your alma mater, the local medical school, or one whose work you want to support.

3. You have the option of designating whether your contribution will benefit the Medical School Excellence Fund, which allows

schools to use the funds where they are needed most, or the Medical School Assistance Fund, which enables medical schools to provide financial aid to students through scholarships and loans.

4. You know how your money is used by the medical school — for visiting faculty, library improvements, laboratory equipment, etc — since Alliance leaders are in contact with the deans and can share this information with you.

5. You let the public know that the medical community is committed to quality health and medical care — and that helps to strengthen relationships between physicians and their patients.

6. Your participation in medical community fundraisers such as

auctions, raffles, and sports events increases awareness of AMA-ERF, as well as the contributions to medical education.

The *four* funds that may be selected when you choose to do so:

The *MEDICAL SCHOOL EXCELLENCE FUND* provides unrestricted grants. This allows medical schools to use the money where it is most needed. Funds have been used to support programs for women and minority students; to purchase publication subscriptions, computer software, and other equipment; to subsidize student activities, research projects, guest lectures, and attendance at conferences and meetings; and to finance numerous projects that add to the excellence of the medical education experience.

The *MEDICAL STUDENT ASSISTANCE FUND* — An average of \$500,000 has been given each year to financial aid programs since the Medical Student Assistance Fund was established in 1983. Medical schools must use these gifts to help students pay educational costs through loans, grants, or scholarships. Donors have the option of choosing their school that will benefit from their gifts.

The *DEVELOPMENT FUND* — A gift to this fund might support a research, experimental health, or medical program. Each year a portion of these funds is used to sponsor the National Student Research Forum, along with Regional Forums. The AMA-ERF Board of Directors uses this fund to respond to various grant requests.

The *CATEGORICAL RESEARCH GRANT FUND* — Grants from this fund come from donors who request that their contribution support research in a specific field, such as cardiovascular or pulmonary disease, arthritis, cancer, diabetes, or multiple sclerosis. Requests for grants from this fund are also considered by the AMA-ERF Board of Directors.

You must remember that these

contributions are more than just charitable donations — they are a legacy from one generation of medical professionals to the next and an investment in the health of generations to come.

AMA-ERF gifts are collected from January to December and distributed once a year. As requested by the donor, gifts can be special handled and sent to the designated schools as they are received. Contributions to school chairs may be handled in this manner. Each school receives a list of its AMA-ERF contributors every month.

If you choose not to designate a particular medical school or fund, your contribution will be placed in the Development Fund. Medical School Excellence Fund gifts without a school designation are divided equally among all the medical schools; if a state is specified, medical schools in that state benefit equally.

EVERY DOLLAR CONTRIBUTED goes to the fund and school of the donor's choice, since NO ADMINISTRATIVE COSTS ARE DEDUCTED BY THE FOUNDATION.

As a state officer, I often receive questions on AMA-ERF. I hope this article clarifies a lot of them for you. It is a major project of the AMERICAN MEDICAL ASSOCIATION ALLIANCE, our state, and county alliances. We must protect the future of medicine and medical education. This is a great avenue to do so. At some time we may be a patient needing the latest in research capabilities; our grandchildren or children may need help with costs incurred during medical education. If you have moved to the United States and your spouse's practice is here, it is customary to support the community and profession where you live. With special handling, AMA-ERF contributions may be directed to some foreign medical schools who still have certified education programs, if you haven't chosen a program in the United States.

Another point to remember is to send your contributions to your county or state alliance AMA-ERF chairperson. *Do Not Send* contributions directly to the medical schools. The AMA-ERF FUND *will not receive credit* for your contribution.

I'd like to thank the many members who have supported AMA-ERF each year. Once you meet a new physician who has been a recipient of these monies or you have had a family member benefit from medical research supported by AMA-ERF grant monies, you will wish you could have done more. The requests for our contribution dollars are many; but this is one of the worthiest causes that supports our spouse's profession. Please, continue your support. Thank You.

**Marla Vieillard
KMAA President**

Goodin Elected to AMA Council on CME

Editors Note: At the December meeting of the AMA House of Delegates, Robert R. Goodin, MD, Immediate Past President of KMA, was elected to fill a vacancy on the prestigious AMA Council on Medical Education. The Journal has received the following letter from Dr Goodin, and on behalf of the editors, we wish to congratulate him.

I would like to publicly thank the many individuals and organizations who contributed funds and many hours of time to my campaign for a seat on the Council on Medical Education of the American Medical Association. Thanks to those efforts, our campaign was successful at the AMA Interim Meeting in Washington, DC, December 1-6, 1995. I will work very hard on your behalf and on behalf of U.S. medical students and residents to keep our medical education system the best education system in the world. My sincere thanks to:

- Kentucky-AMA Delegates:
 Don Barton, Chair Wally Montgomery
 Ardis Hoven Don Swikert
- Kentucky AMA Alternate Delegates:
 Greg Cooper Bob Deweese
 Preston Nunnelley Bill Monnig
- AMA Past President Hoyt Gardner
- KMA Staff: Bob Cox, Bill Applegate, and especially Bob Klingsmith
- Campaign Committee: Jo-Ann Daus, Gloria Griffin, and Carol Goodin
- KMA President Danny Clark and Mrs Joyce Clark
- KMA Board Vice Chair Scott Scutchfield
- JCMS and Executive Director Lelan Woodmansee
- Fayette County Medical Society Executive Director Carolyn Kurz
- Kentucky Chapters, American Academy of Family Practice, American College of Physicians, American College of Cardiology, and American College of Surgery
- Kentucky Chapter, Medical Group Practice Management Association
- Dozens of Kentucky Physicians who made campaign contributions

Robert R. Goodin, MD

Dysphagia: Diagnosis and Treatment in Kentucky

Since the publication of our article entitled "Dysphagia: Diagnosis and Treatment in Kentucky" in the May 1995 edition of the *Journal of the Kentucky Medical Association*, I have received three letters from hospitals within the State of Kentucky clarifying their current status on dysphagia diagnosis and dysphagia treatment. Since our original survey was performed early in 1993, I would like to use this letter to update the readers on further services that are now available.

The following changes should be made in Figure 1 (pages 204-205):

1. Baptist Regional Medical Center in Corbin, KY reports that they are able to do outpatient dysphagia

treatment and outpatient modified barium swallow services with all consistencies. Therefore they should be located on both Map A and Map B in the South-Central region.

2. Jenny Stuart Medical Center in Hopkinsville, KY, indicates that they are able to provide outpatient dysphagia treatment and outpatient modified barium swallow services with all consistencies. Therefore they should be located on both Map A and Map B in the West/Southwest region.
3. Cardinal Hill Rehabilitation Hospital in Lexington, KY, which previously was listed on Map A as No. 25 for outpatient dysphagia treatment can now also do outpatient modified barium swallows with all consistencies and should be located on Map B in the Central region.

I would like to thank each of these facilities for paying close attention to the publication of our article about dysphagia. Their quick response to oversights will allow us to continue to update the availability of services in the State of Kentucky. If there are other hospitals that are currently providing services that are not mentioned, I would ask them to please respond to my attention at Cardinal Hill Rehabilitation Hospital so that we can continue to update this through the "Letters to the Editor" section.

James W. Atchison, DO
Assistant Professor
Dept of PM&R
University of Kentucky

Attending Physician
Cardinal Hill Rehabilitation Hospital
Lexington, Kentucky

RURAL KENTUCKY MEDICAL SCHOLARSHIP FUND, INC.

The Rural Kentucky Medical Scholarship Fund is accepting applications from residents of Kentucky, who have been accepted at the University of Kentucky College of Medicine or the University of Louisville Medical School. The Fund offers a \$12,000 loan for each year of medical school to a qualified recipient who is willing to practice and reside in a rural county in Kentucky for one year for each loan received. The interest rate is determined on May 1. Repayment options include low interest rates for recipients practicing in rural areas and loan forgiveness for those practicing in areas of the state with critical needs. The Fund is the oldest and most successful of its kind in the nation. The Rural Kentucky Medical Scholarship Fund has loaned approximately \$4 million to over 600 medical students. The deadline date for filing an application is *April 1*. Those interested in applying for a scholarship loan should contact the RKMSF Office at the Kentucky Medical Association Headquarters, 301 N. Hurstbourne Parkway, Ste. 200, Louisville, KY 40222, or call 502-426-6200.

1996

JANUARY

26 — New Trends in the Management of Prostate Cancer, Radisson Plaza Hotel, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333 — 606/323/5161 or FAX 1/606/323-2008.

28-February 3 — Practical Aspects of Diagnostic Radiology/Medical Imaging, Silvertree Hotel, Snowmass Village, CO, sponsored by Vanderbilt University Medical Center. Contact: Marilyn J. D'Asaro, Manager/Program Coordinator, Div of CME, Vanderbilt University School of Medicine, D-8211 Medical Center North, Nashville, TN 37232-2337; phone 615/322-4030.

FEBRUARY

4-7 — Southeastern Surgical Congress, Hyatt, Tampa, FL. Contact: Sec/Dir, R. P. Burns, MD, UT Coll of Med, 921 E 3rd St, Ste 400, Chattanooga, TN 37403; phone 404/607-8958.

5-7 — Cardiovascular Conference at Snowshoe (1621), Snowshoe, W VA. Sponsored by the American College of Cardiology. Contact: American College of Cardiology, 9111 Old Georgetown Rd, Bethesda, MD 20814-1699; phone 800/257-4739; FAX 301/897-9745.

15 — Physician's HIV Update, (KAETC), Lexington, KY. (Call University of Kentucky — 606/256-1279 — for location and times).

25-March 1 — 27th Annual Family Medicine and Primary Care Review, Hyatt Regency, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323/5161; or FAX 1/606/323-2008.

MARCH

8-9 — 24th Annual C. Dwight Tawnes Memorial Seminar, Seelbach Hotel, Louisville,

KY. Contact: Office of CME, University of Louisville School of Medicine, Louisville, KY 40292; phone 502/852-5329, or FAX 502/852-6300.

16-17 — Topics in Geriatrics, French Quarter Suites, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323-5161; or FAX 1/606/323-2008.

18-22 — PET and SPECT Imaging in Cancer Diagnosis and Treatment; Ihilani Resort and Spa, Kapealei, Hawaii. Sponsored by Johns Hopkins University School of Medicine. 17 credit hours in Category I of the Physician's Recognition Award of the AMA. Contact: Program Coordinator, Johns Hopkins Medical Institutions, Office of Continuing Medical Education, Turner Building, 720 Rutland Ave, Baltimore, MD 21205, phone 410/955-2959; or Julia W. Buchanan, Course Co-Director, 410/955-8572.

APRIL

12-13 — Aggressive Management of Obesity, Diabetes and Dyslipidemia, Hyatt Regency, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323-5161; or FAX 1/606/323-2008.

18 — Physician's HIV Update, KAETC, Lexington, KY. (Call University of Kentucky — 606/257-1279 — for location and times).

25-28 — 77th Annual Session, American College of Physicians; San Francisco Moscone Convention Center. Contact: Annual Session Hotline, 800/423-1546, ext 2600 or 215/351-2600 (9 am-5 pm ET).

26-May 3 — 55th Annual American Occupational Health Conference, San Antonio Convention Center, San Antonio, TX. Contact: ACOEM, 55 W Seegers Rd, Arlington Heights, IL 60005; telephone, 708/228-6850; FAX 708/228-1856.

MAY

10-11 — Contemporary Pediatrics, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323-5161; or FAX 1/606/323-2008.

19-24 — 27th Annual Family Medicine and Primary Care Review, Hyatt Regency, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323-5161; or FAX 1/606/323-2008.

JULY

10-14 — Internal Medicine Board Review, Hilton Suites, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323/5161; or FAX 1/606/323-2008.

OCTOBER

18-20 — Diagnostic Radiology, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323-5161; or FAX 1/606/323-2008.

19 — Neurology for Primary Care Provider, Radisson Plaza, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323-5161; or FAX 1/606/323-2008.

NOVEMBER

10-15 — 27th Annual Family Medicine and Primary Care Review, Hyatt Regency, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323-5161; or FAX 1/606/323-2008.

21-22 — Perinatal/Neonatal Symposium, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323-5161; or FAX 1/606/323-2008.

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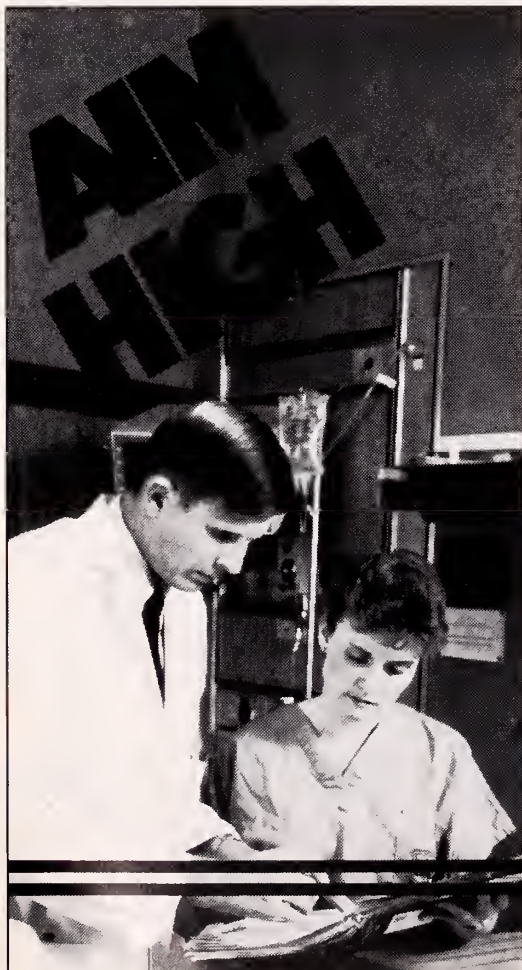
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Kentucky Statewide CATO Society Meeting

In conjunction with the Kentucky Medical Association Annual Meeting at the Hyatt Regency Hotel in Lexington, the CATO Society met in the Washington Room on Wednesday, September 20, 1995. This was the sixth statewide meeting since it was first scheduled in Louisville on 26 September 1990, and several representative photographs of participants have been reproduced.

Before the scheduled time for the breakfast buffet, members began gathering and visiting in the hallway and we moved into the room and contemplated the bountiful buffet. Nearly 40 physicians and guests were present. A list of members in attendance is appended.

There were quite spirited conversations as some of those present enjoyed surprise visits with old friends. There was no prepared program for this statewide meeting as it was thought that the opportunity for visiting with colleagues and friends who would be attending the KMA meeting would be sufficient enticement to attend. Henceforth, however, the statewide meeting will have a brief planned program.

It has been suggested that this statewide CATO Society meeting may be the ideal opportunity for all of us who have retired and left the mainstream of medicine to hear from the deans of our two Kentucky medical schools about medical education for the present generation. If feasible, such a program will be arranged.

Eugene H. Conner, MD

Cassady, Ballard W., MD
Conner, Eugene H., MD
Crabtree, Carson E., MD
Crawford, Kenneth P., MD
Davis, James W., MD
Durham, William C., MD

Gaines, Frank M., MD
Hopkins, William E., MD
Jenkins, Douglas H., MD
Kelty, Karl C., MD
Kykins, Robert W., MD
Marion, Eugene L., MD
McClendon, Robert L., MD
McManus, William, MD
Moore, L. P., MD
Oldham, William J., MD
Oliver, Earl P., MD
Orr, James A. Jr, MD
Phillips, R. J. Jr, MD
Popham, Bernard I., MD
Roberts, Mack, MD
Rumage, William T., MD
Sehlinger, George A., MD
Stambaugh, Harry D., MD
Weddle, Richard H., MD



Top: Ballard W. Cassady, MD, Pikeville, (R) chatted with Kenneth P. Crawford, MD, of Louisville. Center L to R: Richard H. Weddle, MD, came in from Somerset to join his colleagues. Mack Roberts, MD, Monticello, takes a break with Karl C. Kelty, MD, of Lexington. Bottom L to R: Owensboro colleagues R. J. Phillips, Jr, MD, William J. Oldham, MD, and William A. McManus, MD.

PEOPLE

Two KMA members are among 50 physicians nationwide selected to be featured in the Positive Profiles Project supported by the American Hospital Association. They are **Mark S. Weis, MD**, a family physician practicing in Scottsville, and **Leah Dickstein, MD**, associate dean for faculty and student advocacy at the University of Louisville School of Medicine.

The 50 doctors were named following a yearlong search conducted by The Positive Medicine Project, a Philadelphia-based group whose focus is on selecting physicians who are patient-centered, exhibit commitment to professional collaboration, are involved in community leadership, and possess a philosophy of continuous improvement based upon a foundation of professional positivity. More than 300 doctors were nominated, with the list ultimately trimmed to the 50 deemed to be the best examples of positive medicine. This is the first such listing by the group.

The final list represents 31 states and includes 23 physicians in primary care and 27 who primarily practice specialized care. The honorees include 8 pediatricians, 4 ob-gyns, 11 family practitioners, 17 internists, 7 surgeons, 2 psychiatrists and 1 emergency room doctor. They range in age from 31 to 87.

The names of the 50 physicians on the most positive list will be featured in a forthcoming book, *America's Most Positive Physicians*.

Dr Weis is a graduate of the University of Kansas and has practiced at The Medical Center in Scottsville since 1992.

Dr Dickstein taught English in Ghent, Belgium, and in inner-city Brooklyn before entering the

University of Louisville School of Medicine. She graduated in 1970. Dr Dickstein has co-edited three books, is president-elect of the American Association for Social Psychiatry and a past president of the American Medical Women's Association.

Eugene H. Shively, MD, KMA 4th District Trustee, Campbellsville, has been elected Governor-at-Large from the state of Kentucky to the American College of Surgeons.

Joseph E. Kutz, MD, KMA 5th District Trustee, Louisville, was recently honored by the Volunteers of America of Kentucky for his involvement in community affairs. Dr Kutz is a surgeon specializing in hand and reconstructive microsurgery.

Will W. Ward, Jr, MD, Louisville, has been honored by the American College of Physicians with their Community Service Award. The ACP paid tribute to Dr Ward's extraordinary commitment to society's less fortunate, particularly his work on behalf of the Jefferson County Medical Society's Outreach Program, Inc, dba The Healing Place. A founder of the program, Dr Ward has served as President since its inception in 1989.

John R. Barton, MD, a Lexington ob-gyn specializing in maternal-fetal medicine, continues his work in the pregnancy complication of pre-eclampsia. He has published a number of articles on the clinical management of this disorder, including the largest series on outpatient management of mild gestational hypertension (592 patients) in the literature to date. In addition, he has authored the world's first published case of recurrent acute fatty liver of pregnancy, a complication of pregnancy previously associated with an 85% maternal mortality.

The following KMA members were included in recent faculty promotions at the University of Louisville School of Medicine. **David G. Changaris, MD**, neurology, associate clinical professor; **Robert D. Fechtner, MD**, ophthalmology and visual sciences, associate professor; **Michael B. Flynn, MD**, surgery, professor; **Michael F. Heine, MD**, anesthesiology, associate professor; **Fred J. Hendler, MD**, medicine, professor; **Walter D. Jones, MD**, pathology, clinical professor; **Richard H. McChane, MD**, pediatrics, associate professor; **Michael D. Needleman, MD**, family and community medicine, associate clinical professor; **Manjula K. Pandit, MD**, medicine, associate professor; **Karen Berg Pass, MD**, diagnostic radiology, assistant professor; **Dwight D. Pridham, MD**, obstetrics and gynecology, associate professor; **Patricia M. Quinby, MD**, family and community medicine, associate professor; **Julio A. Ramirez, MD**, medicine, associate professor; **Igor Singer, MD**, medicine, professor; **Bennie C. Slucher, MD**, pathology, assistant clinical professor; **Steven H. Stern, MD**, medicine, associate professor; **John E. Stocking, MD**, anesthesiology, associate professor.

Gilbert H. Friedell, MD, director of Cancer Control at the Lucille Parker Markey Cancer Center and co-director of the Kentucky Cancer Program, has been named the first recipient of the William E. Lyons Award for Service at the University of Kentucky.

Dr Friedell, who came to UK in 1983, has been a driving force in cancer control in Kentucky. Under his direction, the Kentucky Cancer Program has expanded to include one of the nation's most sophisticated registries for cancer. Also, the Kentucky Cancer Program's nine community-based offices regularly sponsor outreach programs to teach

people about early detection, cancer prevention, and treatment.

The William E. Lyons Award honors an individual associated with the University of Kentucky who has made outstanding contributions to UK, Lexington, or the commonwealth. It is named for the late William E. Lyons, professor of political science and public administration, who was active at UK and in the Lexington community.

UPDATES

KEMPAC Board Appointed

The KMA Board of Trustees appointed the following physicians to the KEMPAC Board of Directors:

William P. VonderHaar, MD

Louisville, Chair

William B. Monnig, MD

Northern KY, Vice Chair

Preston P. Nunnolley, MD

Lexington, Treasurer

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UK College of Medicine Welcomes New Chairs

The University of Kentucky College of Medicine has announced two new chairs. **Terence R. Collins, MD**, is the new chair of the department of preventive medicine and environmental health. Dr Collins' previous appointment was as vice chair of the department. He has been a professor of preventive medicine and environmental health at the College of Medicine since 1989 and was named to that department's Kurt Deuschle, MD Professorship in 1994.

Joseph R. Berger, MD, is the new chair of the department of neurology. Dr Berger's research on the neurological and neuropsychological aspects of HIV infection and novel therapeutic strategies for HIV and its neurological complications is funded by the National Institutes of Health/ National Institutes of Mental Health. Dr Berger was previously professor of neurology at the University of Miami School of Medicine. He is a fellow of the American College of Physicians and the American Academy of Neurology.

U of L Researchers Close in on Possible Cause of Coronary Artery Disease

According to a report from the University of Louisville, the presence of a newly-discovered bacterium in a patient with severe coronary artery disease has brought researchers closer to confirming the theory that the bacterium *Chlamydia pneumoniae* may contribute to heart attacks.

Scientists at the University of Louisville and Johns Hopkins University last year presented evidence that *C pneumoniae* could grow in the cells of arterial walls. The researchers theorized that infection from the bacteria might damage the arteries, encouraging the growth of plaque which narrows blood

passageways and restricts blood flow to the heart.

Working with researchers from the State University of New York-Brooklyn; Providence Medical Center, Southfield, Mich; University of Washington, Seattle; and University of California, San Francisco, the research team has identified, isolated, and grown in culture live *Chlamydia pneumoniae* taken from the arterial walls of a Louisville heart transplant patient. The work was funded by the Jewish Hospital-Rudd Heart and Lung Institute of Louisville.

The findings bring researchers one step closer to adding bacterial infection to the risk factors associated with coronary artery disease. Other factors include elevated cholesterol and blood pressure levels and a history of smoking.

The roots of atherosclerosis long have eluded medical researchers. U of L researcher **Julio Ramirez, MD**, theorized that some patients may develop initial respiratory infections such as bronchitis or pneumonia caused by *C pneumoniae*. From this local infection, the bacterium may reach the blood stream and the coronary artery's endothelial—or smooth muscle—cells, slowly damaging the arterial wall and creating a condition conducive to formation of arterial plaque.

To test this theory, a team led by Dr Ramirez and U of L researcher James Summersgill studied the coronary arteries of hearts removed during transplant operations, immediately preparing them for culture. The teams detected evidence of the bacterium's presence in six of the 12 prepared arteries. In the case of one severely-clogged artery, all three of the medical centers that attempted to isolate and grow the bacterium succeeded.

Dr Ramirez said if infection is confirmed as a risk factor, a vaccine might be developed to prevent atherosclerosis, the chief cause of

death in the United States and Western Europe.

HCFA Releases Final Regulation on Stark I

HCFA recently published its final regulations on the Stark I physician self-referral law for clinical laboratory services. The regulation provides that, if a physician or a member of a physician's immediate family has a financial relationship with an entity, the physician may not make referrals to the entity for the furnishing of clinical services under the Medicare program. This regulation became effective September 13, 1995, with the exception of the reporting requirements which will not go into effect until HCFA develops and issues a form/instructions booklet.

While these final regulations only address referrals to clinical laboratory services covered by Stark I, HCFA states that they intend to rely on language and interpretations in this rule when reviewing referrals for other designated health services covered by Stark II. Services covered by Stark II are: physician and occupational therapy services; radiology services; radiation therapy services and supplies; durable medical equipment and supplies; parenteral and enteral nutrients, equipment, and supplies; prosthetics, orthotics, and prosthetic devices and supplies; home health services; outpatient prescription drugs; and inpatient and outpatient hospital services.

In view of the complexity of these regulations, KMA recommends that physicians discuss this matter with their personal legal counsel in order to determine its impact upon their individualized situations.

HCFA Information Campaign on Mammograms

The KMA Cancer Committee met recently and discussed the Health

Care Financing Administration (HCFA) nationwide public information campaign to encourage women aged 65 and older to get screening mammograms. While Medicare covers screening mammograms for the early detection of breast cancer, Medicare data indicate that more than 60% of older women do not take advantage of this benefit.

The Cancer Committee encourages physicians to discuss mammograms with patients and encourage them to receive mammography at a certified unit. For women aged 65 and older, Medicare helps pay for one screening mammogram every 2 years. Medicare covers diagnostic mammograms when a woman shows any signs of breast disease. For Medicare-eligible women of any age, diagnostic mammograms are covered when ordered by their doctors.

For a list of certified mammography units in Kentucky, please contact the Department for Health Services, Cancer Section, at 502/564-7996.

CLIA Regulations Curb Patient Access to Lab Services

Patient access to laboratory services has suffered as a result of the Clinical Laboratory Improvement Amendments (CLIA) regulations, according to a new study conducted by Mathematica Policy Research of Princeton.

According to the study, about two-thirds (63%) of physicians dropped some or all in-office laboratory tests because of CLIA. The restrictive regulations have been especially hard on rural physician practices, almost three-quarters (72%) of which eliminated or reduced in-office testing. Costs have also increased because of CLIA. Among practices that have increased fees for on-site laboratory testing, 85% say CLIA had an impact on the cost.

CLIA Questions?

Brief but comprehensive information on commonly asked office laboratory questions and the 1988 CLIA regulations is now available at no cost via same-day FAX to physicians and their staffs through the Commission on Office Laboratory Accreditation (COLA). Please direct all questions/inquiries to the COLA Customer Service hotline at 1-800/298-8044.

KMA Annual Meeting

Mark your calendars. The 1996 KMA Annual Meeting will be held at the Hyatt Regency/Commonwealth Convention Center, Louisville, on September 25-28.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

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5012 Old Federal Rd, Louisville 40207
1986, U of Louisville

Edmonson

Pravin N. Avula, MD — IM
PO Box 369, Brownsville 42210
1989, Madras U, India

Fayette

Richard A. Blake, MD — C
1221 S Broadway, Lexington 40504
1989, U of Kentucky
James S. Pezzi, MD — GE
1221 S Broadway, Lexington 40504
1986, Temple U

Franklin

Anthony G. Barnes, MD — FP
430 Goebel Dr, Frankfort 40601
1991, U of Kentucky

Graves

Durwood W. Flournoy, MD — IM
1029 Medical Center Dr Ste 200,
Mayfield 42066

1976, U of Arkansas
Sabina E. Seitz, MD — GP

1112 Links Ln, Mayfield 42066
1989, U of Alberta, Canada

David R. Zetter, MD — FP
PO Box 158, Arlington 42021
1988, U of Alberta, Canada

Grayson

Kenneth M. Sample, MD — S
908 Wallace Ave Ste 109, Leitchfield
42754
1984, U of Louisville

Harlan

Frederic D. Leary, Jr, MD — FP
200 Church St, Lynch 40855
1989, U Coll Galway, Ireland

Henderson

Ricky J. Ballou, MD, PhD — HEM
706 N Burkhardt, Evansville 47715
1989, U of Louisville

Clement F. Bernard, MD — C
319 8th St, Henderson 42420
1988, Hahnemann

James M. Esser, MD — R
711 N Main St, Henderson 42420
1985, U of New York, Buffalo

Hardin

Chris J. Godfrey, MD — IM
820 Greenview Cir, Elizabethtown
42701
1992, U of Kentucky

Jefferson

Ashok V. Alur, MD — IM
3006 Wooded Meadow Ct, Louisville
40241
1980, JJM Med Coll, India

Juergen Helmut B. Bertram, MD — HEM

250 E Liberty St, Ste 802, Louisville
40202

1971, Justus Liebig, Germany
Roberto Bolli, MD — C

3540 Woodside Rd, Louisville
40222-5959

1976, U of Perugia, Italy
Maurice Cruz, MD — PD

9323 Springbrooke Cir, Louisville
40241

1980, Esc de Med Juan N Corpas,
Columbia

Malcolm H. Fine, MD — GP
2105 High Ridge Rd, Louisville 40207

1959, U of Louisville
James E. Hartert, MD — IM

101 E Main St, Ste 12 West, Louisville
40201

1980, U of Minnesota

Craig A. Lundquist, MD — R
3133 Chickering Woods Dr, Louisville
40241

1983, U of Washington

Fritz Moise, MD — FP
868 Markham Ln, Louisville 40207

1979, Haiti U, W Indies

Denis P. Raleigh, MD — S
3711 Norbourne Blvd, Louisville 40207

1983, Baylor
Mary A. Vaccarello-Cruz, MD — PD

1169 Eastern Pky Ste 2343, Louisville
40217

1980, Esc de Med Juan N Corpas,
Columbia

Johnson

Charles L. Smith, DO — GP
PO Box 1587, Paintsville 41240

1982, WV Sch of Osteopathic Med

McCracken

Douglas C. Taylor, MD — ORS
PO Box 7745, Paducah 42002-7745

1986, Dalhousie U, Canada

Northern Kentucky

John A. Darpel, MD — OBG
20 Medical Village Dr, Ste 302,
Covington 41017

1991, U of Kentucky

James A. Eppley, MD — P
375 Thomas More Pkwy, Ste 209,
Crestview Hills 41017

1989, U of Cincinnati

Shaheed I. Koury, MD — EM
822 Riverwatch Dr, Crescent Springs
41017

1992, U of Kentucky
Kevin J. Miller, MD — C

215 Thomas More Park, Ste A,
Crestview Hills 41017

1989, U of Louisville
Scott Neltner, MD — D

8238 Pine Knoll Ct, Florence 41042

1990, U of Louisville

Bradbury A. Skidmore, MD — NS
20 Medical Village Dr, Ste 105,
Edgewood 41017

1987, Wright State

John W. Sprague, MD — OBG
1 Medical Village Dr, Edgewood 41017

1980, U of Cincinnati

Pulaski

Christine Weyman, MD — PD
126 Volunteer Drive, Somerset 42501

1982, Middlesex Hosp Med Sch,
England

Warren

Patricia J. Mercer, MD — A
201 Park St, Bowling Green 42101

1984, U of Louisville

Wayne

David B. Mayer, DO — S
One S Creek Dr, Ste 112, Monticello
42633

1980, Kirksville Coll of Osteopathy
and Surgery

Whitley

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65 Pin Oak Tr, London 40741

1991, U of Louisville

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DEATHS**Antero J. Avenido, MD
Elizabethtown
1938-1995**

Antero J. Avenido, MD, an anesthesiologist, died September 8, 1995. Dr Avenido graduated from Manila Central University in 1964 and was an active member of KMA.

**Joe T. Pettey, MD
Russell Springs
1922-1995**

Joe T. Pettey, MD, a general practitioner, died September 30, 1995. A 1951 graduate of the University of Louisville School of Medicine, Dr Pettey was an active member of KMA.

**Lewis E. Wesley, MD
Liberty
1927-1995**

Lewis E. Wesley, MD, a general practitioner, died October 19, 1995. Dr Wesley was a 1956 graduate of the University of Louisville School of Medicine and an active member of KMA.

**Roy G. Wilson, MD
Campbellsville
1908-1995**

Roy G. Wilson, MD, a retired family practitioner, died October 26, 1995. A 1943 graduate of the University of Louisville School of Medicine, Dr Wilson was a life member of KMA.

**Owen S. Ogden, MD
Louisville
1910-1995**

Owen S. Ogden, MD, a retired pediatrician, died October 29, 1995. Dr Ogden was a past president of the Louisville and Kentucky Pediatric Societies and a Fellow of the American Academy of Pediatrics.

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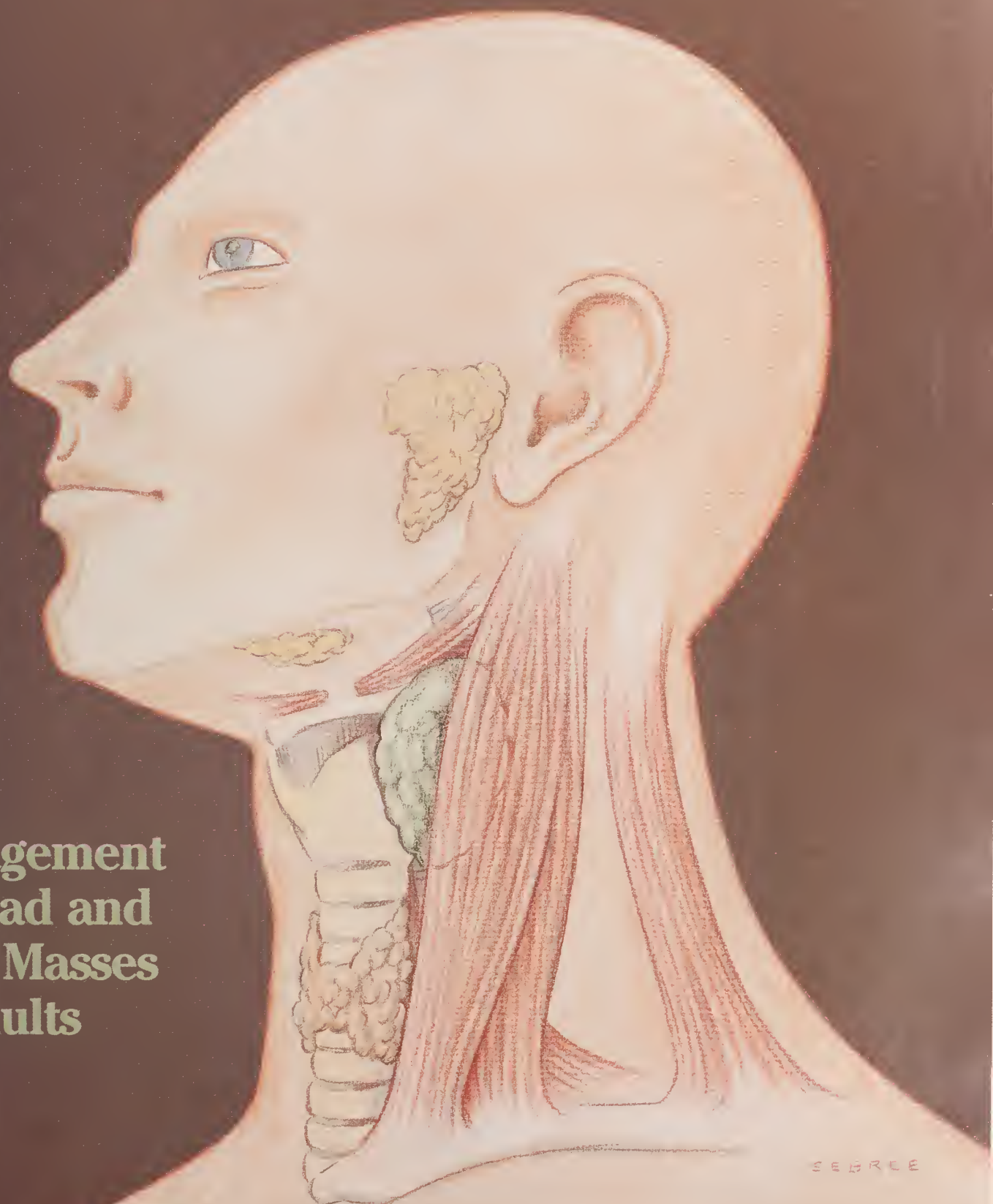
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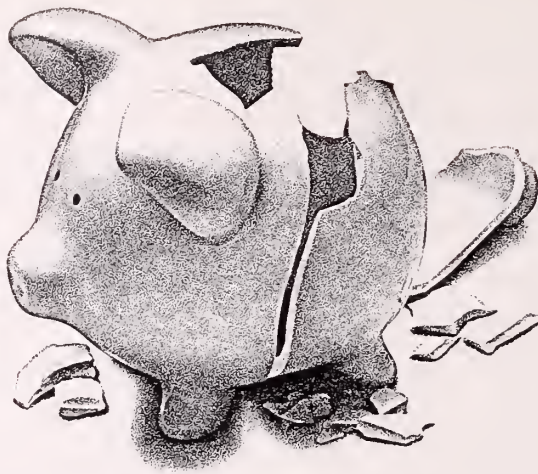
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Management of Head and Neck Masses in Adults

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| | | |
|------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------|
| COVER STORY | Practical Steps in the Management of Adult Head and Neck Masses (Grand Rounds) <i>Jeffrey M. Bumpous, MD; Michael B. Flynn, MD</i> | 50 |
| SCIENTIFIC | Treatment of Pneumothorax in the Patient with AIDS <i>Carolyn E. Becker, MD; Mark Reynolds, MD; Thomas M. Roy, MD</i> | 59 |
| SPECIAL ARTICLE | Development of a Statewide Trauma System: Classification of Levels of Care Available to Injured Patients <i>J. E. Svenson, MD; J. S. Stapczynski, MD; M. Nypaver, MD; R. Calhoun, MPH</i> | 63 |
| EDITORIAL | When a History of Physical Abuse Is License for Societal Abuse <i>Martha K. Heyburn, MD</i> | 71 |
| ASSOCIATION | <i>Monitoring Medicine</i> KMA Board of Trustees — December Meeting 1996 KMA Practice Management Seminars News | 47 74 79 76 |
| DEPARTMENTS | President's Page Advertisers' Guide Alliance Page Classifieds Information for Authors Letters to the Editor | 45 82 73 81 56 72 |



COVER: The most important adjective in the evaluation of masses in the head and neck is to identify or exclude a malignancy. The purpose of this article is to assist the primary care physician in understanding the principles of diagnosis of these masses in the adult and to provide an efficient diagnostic algorithm that delineates testing and referral criteria. Artwork by Stephen Sebree of Louisville. (With permission to reprint from Drs Bumpous and Flynn.)

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They Is Us

Conversations abound in physician lounges and other areas where physicians congregate and kibitz about matters relating to patient care. Most physicians turn to the federation of medicine seeking answers — placing blame — and on a rare occasion provide a pat on the back to those representing us.

It puzzles me to hear physicians speak of the KMA in the third person and characterize elected physician representatives as colleagues not of their realm. At a recent KMA meeting a member while discussing his state representative — and apologizing for his representative voting for the tax — and co-sponsoring HB 250 — said, quote, “He likes doctors but doesn’t like KMA,” unquote. Give some thought to that!

So who is the KMA? The KMA is you and me. We are 4,300 voluntary physicians residing in 120 counties made up of 44 specialties and subspecialties. Fifty-four percent of your peers have chosen to belong to the AMA. Membership is composed approximately 50-50 in terms of rural and urban. Across the state 43% of physicians are primary care, 47% non-primary care.

The most important function of the KMA is to represent the profession and our patients in the scientific, social, economic, and political arenas and to promote the collective and corporate views of the profession as enunciated by our governing structure. The governing structure is crucial to any organization’s success

and it is important that we occasionally review our methods of operation.

Perhaps no other organization is more democratic than ours. The Association’s governing structure reflects very well physicians’ belief in the individual’s right and the exercise of constitutional rights. Every member has a voice in their county society — every member can present a resolution to the KMA House of Delegates — every county is given a proportional vote. It is not uncommon for a single Kentucky physician to present a resolution to the KMA House of Delegates and later see that same resolution become the policy of AMA — hence, it becomes national medical policy.

While the House of Delegates is not in session the Board of Trustees represents the Association on all matters. While the Board is bound by House policy, it may respond to and react on issues which the House has not considered. The Board is composed of 15 trustees who are elected by their trustee districts; every officer and ten AMA delegates and alternate delegates are directly elected by the House of Delegates. The 1996 Board is made up of 32 positions — with some dual elective spots; actually 30 physicians serve. Primary care physicians fill 15 of 30 positions. Approximately two-thirds of the Board reside in either rural or small cities. Nine physicians represent Lexington and Louisville.

This exercise is simply an attempt



Donald R. Stephens, MD

“It puzzles me to hear physicians speak of the KMA in the third person and characterize elected physician representatives as colleagues not of their realm.”

to paint a picture of who we are and what the KMA truly represents. While we are fiercely independent cusses by nature, we still recognize the need to associate and recognize the need for unity. Besides — occasionally there is a need to circle the wagons — and it’s nice to know who is in that circle.

Donald R. Stephens, MD
KMA Vice President

Dr. Lonnie Bristow Speaks To America's Patients About Medicare Reform:

I'm a practicing physician and I want my patients to know that Medicare will go broke by 2002 unless it's fixed now. The AMA has been working 10 years on ways to improve Medicare. Now Congress is about to act, and you need the straight story about what is really going on. Here are answers to questions patients ask me the most about the Medicare mess.

1. Does anyone have an answer?

The House Leadership has a plan that makes sense, tackles the hard financing problem and is good for patients. Most important, spending per person will *still* rise from \$4,800 to \$6,700 in 2002.

2. Will I have to give up what Medicare already gives me?

No. You can keep the security of traditional Medicare if you want. You won't have to do anything different.

3. Can I choose my own doctor and my own health plan?

Yes. In fact, patients will have more choices, including traditional Medicare, private insurance plans or a tax-free medical savings account.

4. How much more will it cost me?

You will pay a little more, but not a lot more. On average, monthly premiums will rise only \$6 a year over the next seven years. If you choose a private sector health plan, there may be expanded benefits and lower out-of-pocket expenses.

5. Will patients be protected?

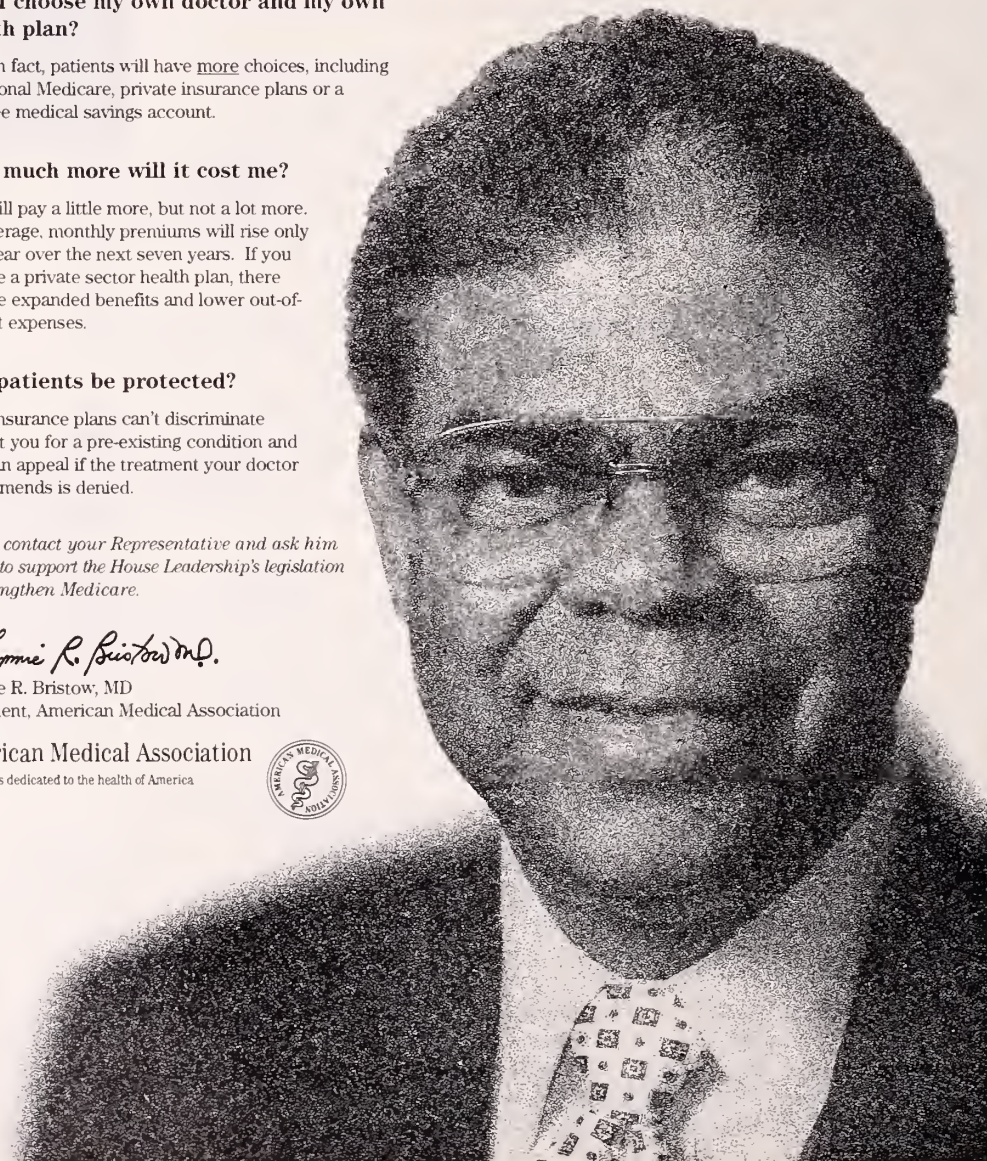
Yes. Insurance plans can't discriminate against you for a pre-existing condition and you can appeal if the treatment your doctor recommends is denied.

Please contact your Representative and ask him or her to support the House Leadership's legislation to strengthen Medicare.

Lonnie R. Bristow MD.

Lonnie R. Bristow, MD
President, American Medical Association

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MONITORING MEDICINE

NEWS FOR KENTUCKY PHYSICIANS

During the debate over House Bill 250 the KMA leadership submitted the following recommendations to legislators regarding medicine's specific concerns with HB 250.

KENTUCKY MEDICAL ASSOCIATION RECOMMENDATIONS FOR CHANGES IN HOUSE BILL 250

1. The Health Policy Board should become a Health Policy Advisory Board consisting of at least two physicians, one hospital administrator, and others. Physicians should be nominated from nominees provided by the Kentucky Medical Association and appointed by the Governor. The Board members should be volunteers rather than full-time employees and function similar to other state boards. The Board could operate under the CHR and serve as an advisory agency to state government and the legislature on matters of health policy. Responsibilities of the Health Policy Board should be revisited and limited.
2. Health Data Collection — Many of the current requirements under House Bill 250 regarding Health Data Collection for both insurers and providers should be reconsidered and data collection efforts cease until the new Board is in place and determines what data is necessary and how it is to be used.
3. Reconsider current requirements for developing, updating, and recommending clinical practice parameters and outcome measurements for healthcare providers.
4. Health insurance reforms: Portions of existing legislation and regulation regarding preexisting conditions, renewability, portability, and guaranteed issue should be retained. Association plans should continue to be experience rated and their participation in the Alliance should be voluntary.
5. Repeal or amend Section 82, provider of last resort, which establishes a health care discount program for those with incomes up to 200% of poverty where eligible persons pay for services at current Medicaid rates (DOP).
6. Sections 96-114 concern the provider tax. Repeal the provider tax on physicians.
7. Section 115 requires medical records to be provided without charge. This section should be amended to permit providers to charge a reasonable fee to recover administrative and actual copying expenses.
8. Retain the Any Willing Provider provision which prohibits health care benefit plans (HBP) from discriminating against providers located within the geographic coverage area of the HBP willing to meet terms and conditions for participation established by HBPs.
9. Self-Referral — Repeal those sections of HB 250 pertaining to self-referral. Federal law more than adequately addresses fraud and abuse, self-referral, and related issues.
10. State Health Plan — Currently the Health Policy Board not only establishes rules by which Certificates of Need are granted, it also determines who must comply with those rules. The same agency should not perform both tasks. In addition, the State Health Plan should be a discretionary or advisory document that establishes objective standards for consideration rather than mandating rigid rules or formulas.

11. Provider Sponsored Networks — Retain section authorizing the establishment of provider sponsored networks noting that financial solvency reserves should be different than required of HMOs and other risk-bearing insurance entities.

Workers Compensation Developments Continue . . .

The Kentucky Department of Workers Claims recently promulgated a regulation requiring utilization review and medical bill audit for workers compensation cases. The regulation directs all insurance carriers, self-insured employers, and group self-insurance funds to implement a utilization review program in which medical services and treatments in compensable claims will be subject to review for medical necessity and appropriateness upon: 1) *a medical provider's request for pre-certification*; or 2) notification of a planned surgical procedure or resident placement pursuant to an 803 KAR 25:096 treatment plan; or 3) total medical bills exceeding \$3000.00; or, 4) patient lost work days exceed 30.

The regulation also requires audit of each medical bill to assure that a gatekeeper

physician has been designated and that reimbursement complies with applicable fee schedules. The acute low back pain practice parameter recently approved by the Kentucky Health Policy Board has been adopted by the Department of Workers Claims as criteria for evaluating applicable low back claims.

Department of Workers Claims' Commissioner Walt Turner anticipates that physicians will request workers compensation carriers to pre-certify medical services and that pursuant to the regulations necessity determinations will be made by appropriately trained medical personnel. It is envisioned that through the Utilization Review process physician-carrier disputes will be resolved and Kentucky's industrial health care climate will become less volatile.

Copies of the Utilization Review and Medical Bill Audit regulation, 803 KAR 25:190, and the Selection of Physicians and Treatment Plans regulation, 803 KAR 25:096, are available upon request from the Department of Workers Claims, 1270 Louisville Road, Frankfort, Kentucky 40601, (502) 564-5550. The low back pain practice parameter is available from the Kentucky Health Policy Board, 909 Leawood Drive, Frankfort, Kentucky 40601, (502) 564-4040.

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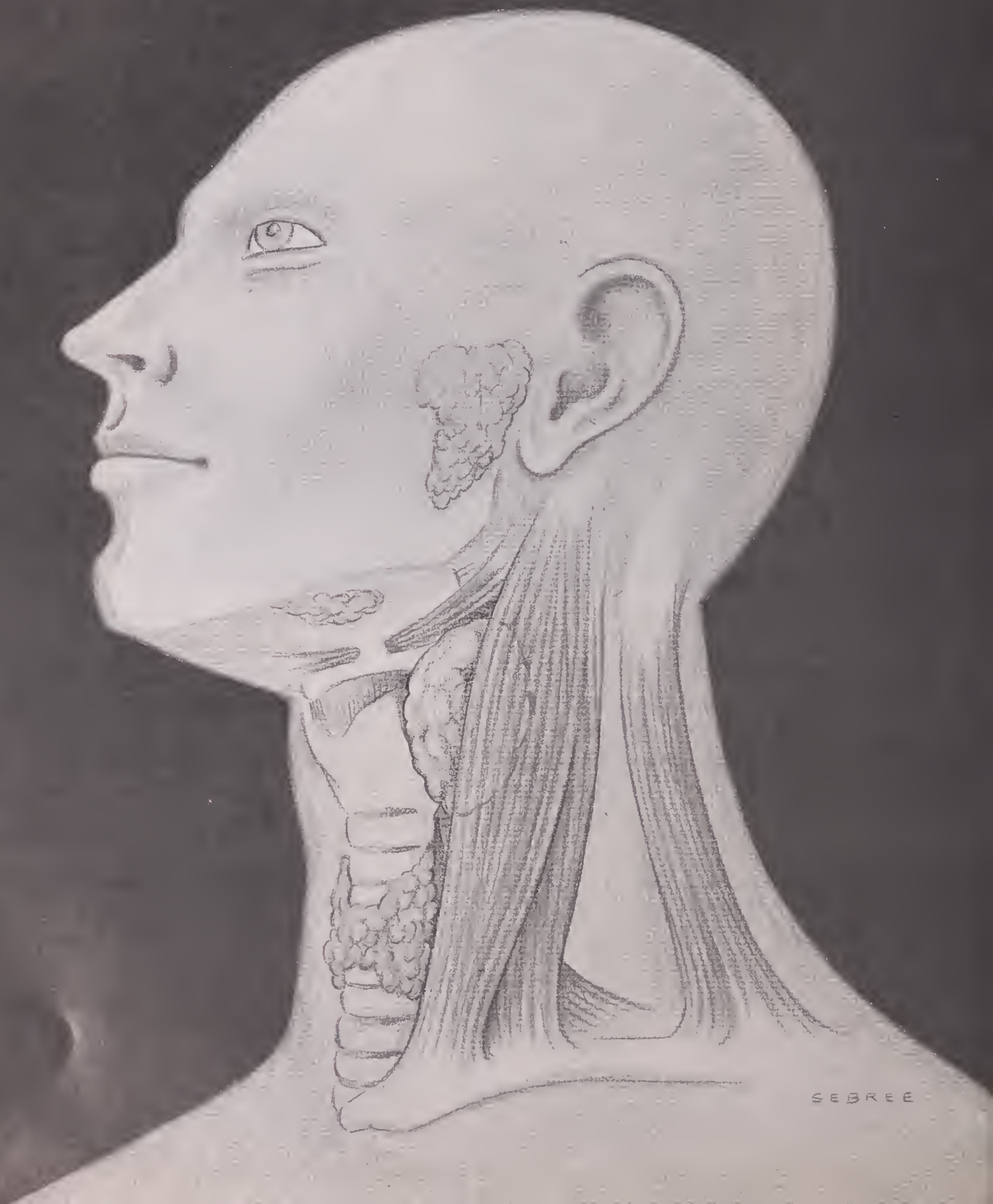
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Practical Steps in the Management of Adult Head and Neck Masses

Jeffrey M. Bumpous, MD; Michael B. Flynn, MD



Evaluation of a mass in the head and neck region may be as simple as recognizing a lipoma or as complex as a clinically malignant neck mass requiring further investigation. Currently, in addition to sorting through the diagnostic possibilities of masses in the head and neck region, this investigation should be conducted in the most efficient, cost-effective manner. The purpose of this article is to assist the primary care physician in understanding the principles of diagnosing head and neck masses in adults and provide an efficient diagnostic algorithm that delineates testing and referral criteria (Fig 1). Because of the potential for congenital, inflammatory, and neoplastic masses in the head and neck region, proper management requires the physician to have an index of suspicion for neoplasm, coupled with a thorough differential diagnosis and an efficient investigative strategy.^{1,2} Review of the most frequent and most important causes of head and neck masses in adults is followed by our approach to diagnosis, including patient history and physical examination, imaging modalities, and biopsy procedures. We recommend diagnostic and therapeutic steps for different levels within the health care system. It is no more appropriate to delay the investigation and management of a clinically malignant neck mass than it is to over-use medical resources to investigate an obvious innocuous condition, such as lipoma.

Causes of Nonmalignant Neck Masses

In all age groups, the most frequent etiology for a mass in the neck is reactive lymphadenitis (Fig 2). This may be secondary to a wide assortment of clinical conditions, varying from infections of the upper respiratory tract, neighboring skin, scalp, or external ear, to systemic conditions such as viral infections or rheumatoid arthritis. A thorough patient history should suggest the specific clinical conditions usually associated with benign reactive nodes. Lesions involving the thyroid and salivary glands represent another frequently encountered nonmalignant neck mass. Thyroid adenoma is the most frequent explanation for thyroid enlargement in both sexes (Fig 3). Other conditions causing benign thyroid enlargement include goiter, thyroiditis, and thyroid cysts. The most common benign salivary gland lesions are tumor or sialadenitis, in that order.^{3,6} Sialadenitis, either acute or chronic, is usually identified based on patient history and physical examination (Fig 4). An important warning regarding sialadenitis is the

awareness that a residual mass following resolution of the acute process may need investigation because of the remote possibility of tumor. Thyroglossal duct cyst or remnant, branchial cleft cysts, and neurogenic tumors, which all have characteristic locations (Figs 5-7) and presentations, represent a very small proportion (less than 10%) of benign head and neck masses. Neurogenic tumors occur in the posterior triangle of the neck along the cervical plexus. Lipomas and sebaceous cysts are relatively infrequent (less than 7% or 8%) and are generally easily identified clinically. Nonmalignant neck masses occur more often in women than in men.⁷

Causes of Malignant Masses

The ability to recognize a mass in the head and neck region with characteristics of a malignancy is an important diagnostic step. The frequency of malignant neck masses varies with age and may be as high as 80% in elderly adults.⁷ Careful history and physical examination should establish an index of suspicion for malignancy. Lesions of recent onset that increase in size or are firm or hard in consistency should all raise the index of suspicion for malignancy. On physical examination, palpable firm or hard masses require a complete evaluation, regardless of the patient's history. Associated findings, such as hoarseness with a para-

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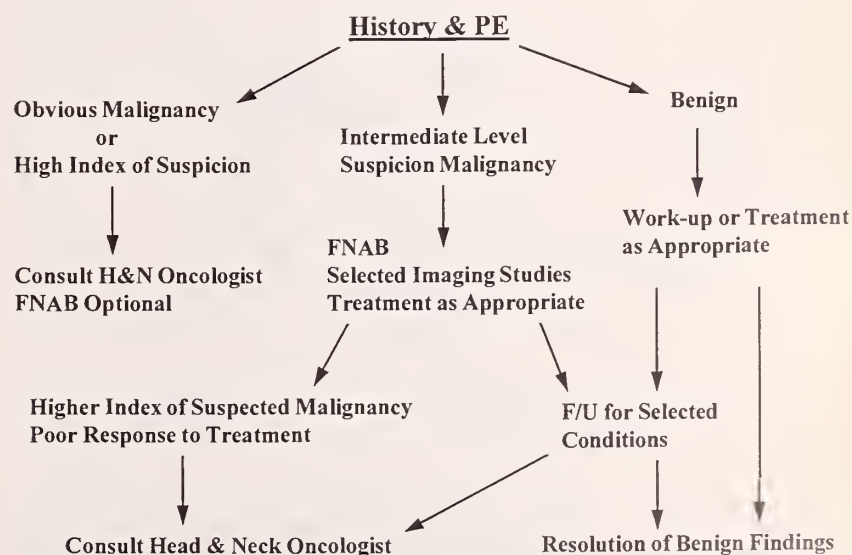


Fig 1 — Algorithm for management of head and neck mass in adults
Abbreviations: H&N, head and neck; PE, physical examination; FNAB, fine needle aspiration biopsy; F/U, follow-up.

Management of Adult Head and Neck Masses



Fig 2 — Reactive Cervical Lymph Nodes

Reactive cervical nodes may occur in any lymphatic drainage basin in the head and neck region. The upper jugular area represents the most frequent site while the submaxillary region and the upper posterior triangle are the next most common. Reactive nodes may be firm or tender, are not usually hard, and are frequently associated with an appropriate history.

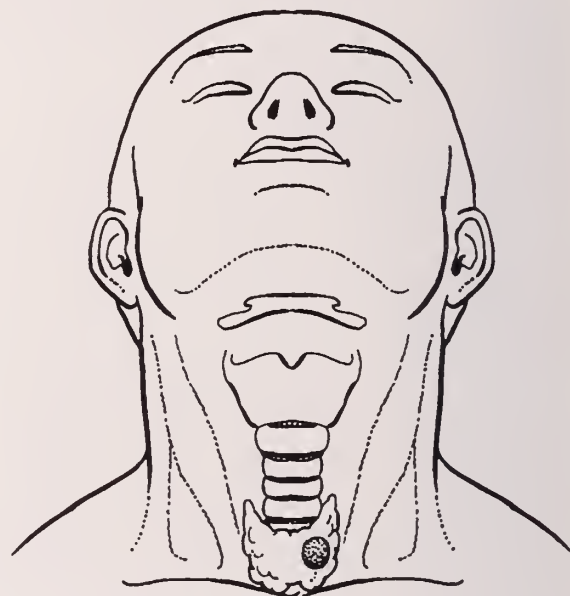


Fig 3 — Thyroid Lesions

Lesions occurring within the thyroid gland are often found in the paratracheal area on either side of the lower neck. Consistency varies with underlying histology. Thyroid lesions exhibit cephalad movement with swallowing. Hardness is an important factor, increasing the index of suspicion for malignancy.



Fig 4 — Salivary Gland Lesions

Lesions in the parotid are located in the pre- and infra-auricular area. Submandibular gland lesions are found in the submandibular region of the neck. This location is best evaluated by simultaneous intraoral and external palpation.

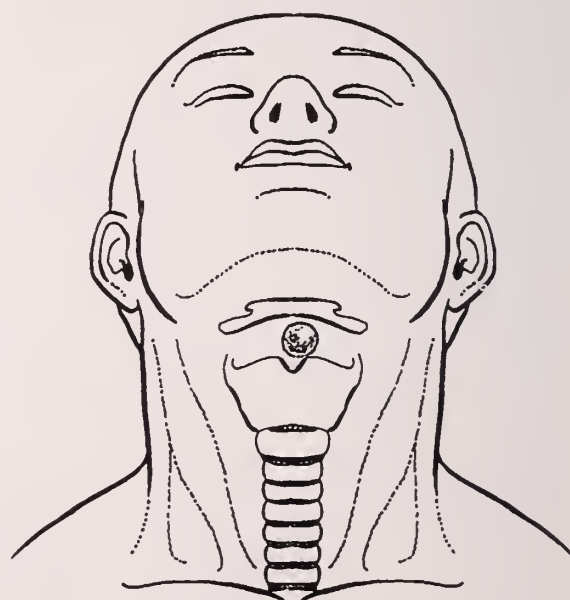


Fig 5 — Thyroglossal Duct Cyst or Remnant

These lesions are usually found between the upper border of the thyroid cartilage and the lower border of the hyoid. They may occur in any location in the anterior central neck and may be somewhat indistinct to palpation.

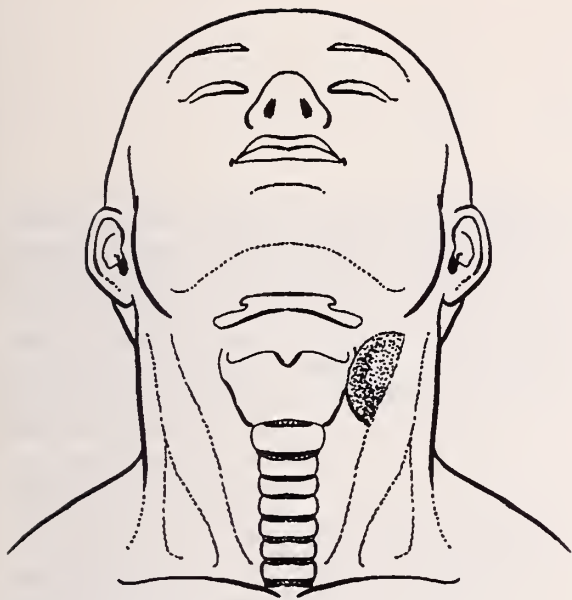


Fig 6 — Branchial Cleft Cyst

Branchial cleft cysts characteristically appear in the upper or mid-third of the neck, along the anterior border of the sternocleidomastoid muscle. It has a firm and somewhat ballotable consistency and characteristic fine needle aspiration biopsy (FNAB) results and computerized tomography (CT) findings.

tracheal mass, suggest malignancy until proven otherwise.

Most studies on the causes of malignant neck masses originate from tertiary care centers. However, these observations often do not accurately reflect the experience with head and neck masses at other levels of the health care delivery system, such as primary care. In an adult, the most important consideration is metastasis to a cervical node from a squamous cell cancer originating in the upper aerodigestive tract. Nodal groups have a characteristic location (Fig 8) and represent specific drainage basins for specific sites within the upper aerodigestive tract. Lymphoma, salivary gland or thyroid tumors, and soft tissue sarcomas represent other possible explanations for a malignant head and neck mass. Rarely, metastatic melanoma may present as a head and neck mass.² Pre- and infraauricular lesions are in the parotid region. A mass in the submandibular (submaxillary) region could represent a salivary gland tumor, sialadenitis, or adenopathy (Fig 4). The paratracheal area of the lower anterior neck is the usual location of thyroid lesions.^{3,6}

Diagnostic Strategies

The diagnostic work-up of a neck mass should proceed in an organized fashion, with studies obtained as indicated by findings on history and physical examination (Fig 1). The patient history should always include the date of appearance of



Fig 7 — Neurogenic Tumors

Neurogenic tumors are usually found in the posterior triangle, along the posterior border of the sternocleidomastoid muscle. They may be quite firm or hard and are extremely difficult to distinguish from a malignancy based on physical characteristics. A long history (many years) is often key to the recognition of neurogenic tumors.

Malignant Lymph Node

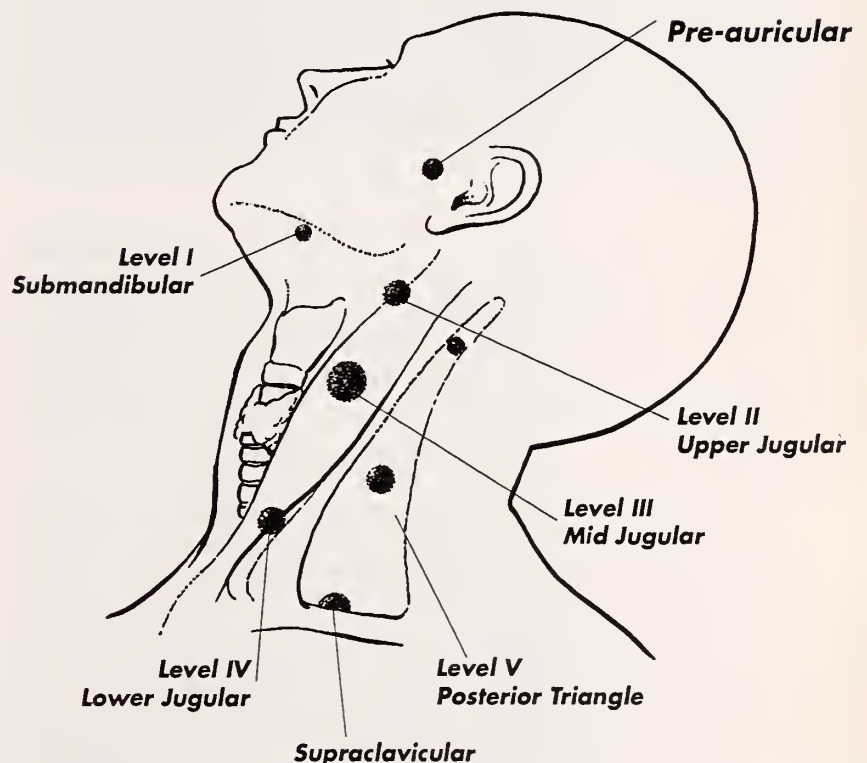


Fig 8 — Malignant Lymph Nodes

Metastasis or primary malignancies (lymphoma) occurring in the head and neck lymph nodes may appear in any of the lymph node drainage basins shown in the illustration. Malignant nodes are usually painless, firm or hard, and may be fixed to neighboring structures. The specific location of malignant neck mass may be used to direct the initial search for primary tumor.

Management of Adult Head and Neck Masses

the mass as well as associated symptoms. The presence of a neck mass in a patient with otalgia and odynophagia should alert the physician to the possibility of an upper aerodigestive malignancy, particularly in a tobacco and ethanol user.^{1,2} Physical examination should consist of a complete assessment of the head and neck, including inspection of the external features of the head and neck, thorough examination of oral cavity, oropharynx (throat), and palpation of the neck. Endoscopy that is performed in the office with a laryngeal mirror and rigid or flexible scopes are helpful if the examining physician is familiar with these techniques. These procedures provide useful evaluation of the status of the nasopharynx, larynx, and hypopharynx. Palpation of the mouth and throat completes the office evaluation of the upper aerodigestive tract. Careful palpation is conducted with special attention to the size, character, location, and mobility of the mass. If a patient presents with a neck mass and hoarseness, an examination of the larynx is imperative. Imaging studies in this patient may appear normal, even with a sizeable laryngeal tumor, and may lull the physician into a false sense of security.⁸ If complete physical evaluation of the head and neck cannot be performed in the primary care setting, this is a reasonable indication for referral.

Many imaging techniques are available to evaluate the head and neck mass. In general, imaging may be used to narrow down a differential diagnosis, help in preoperative planning, or assist in localizing the tumor for needle biopsy procedures. Imaging alone is rarely diagnostic for any particular lesion. Imaging should be used as an adjunct and not a substitution for thorough history and physical examination.

Computerized tomography (CT) may be used to determine size and location, consistency of a mass (cystic versus solid), presence of lymphadenopathy, invasion of bone or other soft tissue, and to some extent vascularity, when contrast material is used. Unless expressly contraindicated, CT scans to evaluate neck masses or adenopathy should include intravenous contrast, which will delineate vascularity of a lesion as well as determine its relationship to the carotid artery and internal jugular vein. Magnetic resonance imaging (MRI) provides better soft tissue detail than CT and allows the lesion to be observed in multiple planes.⁸ MRI is more expensive and less effective in evaluating invasion of bone.^{8,9} Angiography is no longer employed as a diagnostic

imaging modality and should be used at the discretion of the treating surgeon.⁸ Nuclear imaging may be helpful in select thyroid and parathyroid masses. Thyroid scans are not useful in determining whether nodules are malignant or benign because the vast majority of hot and cold nodules are benign. Thyroid scans and sonograms indicate multinodularity and are helpful in evaluating the hyperthyroid patient to rule out Graves' disease versus an autonomously active nodule. Parathyroid imaging is rarely indicated in assessment of a head and neck mass.

If clinical evaluation of a head and neck mass suggests a treatable benign condition such as cervical adenitis or sialadenitis, one or two courses of antibiotics may be reasonable. Poor response to treatment should raise the index of suspicion and consideration for either further investigation or consultation. Modest or intermediate response to treatment may justify another course. If clear benefit is not achieved (ie, substantial reduction in size of mass), consultation should be obtained.

Ultimately, the diagnostic work-up leads to a "tissue diagnosis" of the mass. Fine needle aspiration biopsy (FNAB), large bore needle biopsy, and open surgical biopsy are the primary methods of obtaining a tissue diagnosis of a neck mass.² Physicians performing all types of biopsies must be familiar with the indications and contraindications of specific techniques. Inappropriate use of biopsy procedures, particularly large bore needle and open biopsies, may potentiate spread of malignant tumors and adversely affect the patient's prognosis. Fine needle aspiration has the advantage of being easily performed in the office, carries little morbidity, and is not associated with tumor seeding. If an experienced cytopathologist is not available to evaluate FNAB specimen, the test has severe limitations.² A negative diagnosis does not rule out malignancy and should not deter the physician from pursuing a more aggressive diagnostic procedure if a high index of suspicion for malignancy exists.¹⁰ Large bore needle biopsy, utilizing commercially designed biopsy needles, are only used selectively when malignancy is suspected, due to the risk of seeding. Core needle biopsy is most helpful when FNAB is negative, and open surgical removal and/or biopsy of the mass represents a high medical risk. Open biopsy should be reserved for the surgeon who is experienced in the full range of head and neck surgery. Injudicious open biopsy may result in tumor seeding, worsened prognosis, neurovascular compli-

cations, or interference in standard surgical approaches. Occasionally, open excisional biopsies may be both diagnostic and therapeutic. For example, superficial parotidectomy with facial nerve dissection for a parotid mass, represents an excisional biopsy for diagnosis and is also a therapeutic resection for most benign or malignant parotid tumors.^{2,11}

Indications for Referral

Deciding when to refer a patient with a neck mass can often be confusing. An algorithm, which embodies the principles discussed in the text, is included as a guideline (Fig 1). The decision to refer may be made at many levels and largely depends on the treating physician's experience level, coupled with available radiology and pathology support. In general, if an adequate history or physical evaluation cannot be conducted, referral should be considered prior to diagnostic imaging or biopsy procedures; this may obviate the need to repeat or obtain additional imaging studies by the consulting surgeon. If an adequate examination and differential can be diagnosed, then selected application of imaging and FNAB may be employed. It is important to emphasize that imaging studies should be performed at centers where the radiologist is thoroughly familiar with head and neck imaging. Equally important, FNAB is useful only if the cytopathologist is comfortable with and experienced in head and neck cytopathology.

Common Pitfalls in the Evaluation of the Head and Neck Mass

Most diagnostic errors occur because of inadequate history and physical examination, with an over-reliance on sophisticated imaging techniques. Table 1 delineates common diagnostic errors and possible sequelae in the management of head and neck masses. Avoidance of pitfalls in diagnosis requires adequate history and physical examination, adjunctive use of imaging modalities, and timely and appropriate biopsy. Consultation with a head and neck surgeon is possible at many levels, depending on the preferences of the referring physician and the level of sophistication of radiology and pathology services provided in the local community. When the imaging or biopsy capabilities are uncertain, it is more prudent and cost effective to proceed with referral rather than obtain unnecessary tests.

Table 1. Common Diagnostic Errors in Management of Head and Neck Masses

| Diagnostic Error | Sequelae |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Incomplete History Failure to ask about other head and neck symptoms (ie, otalgia/dysphagia, hoarseness). | Missed primary tumor Delayed diagnosis Unfavorably altered prognosis |
| Inadequate Physical Exam Failure or inability to evaluate remote sites in head and neck (nasopharynx or larynx). | Missed primary tumor Delayed diagnosis Unfavorably altered prognosis |
| Over-Reliance on Imaging for Diagnosis Use of computed tomography (CT) to rule out malignancy after inadequate physical exam. | Missed primary tumor Delay in diagnosis Inappropriate therapy Unfavorably altered prognosis Increased scope of resection Increased surgical morbidity |
| Acceptance of Negative Fine Needle Aspiration Biopsy (FNAB) Acceptance of a non-diagnostic or benign FNAB to rule out malignancy in clinically suspicious mass. | Delayed diagnosis Progression of disease Inappropriate therapy Unfavorably altered prognosis Increased scope of resection Increased surgical morbidity |
| Inappropriate Application of Large Bore Needle or Open Biopsy Open biopsy on patient at high risk for upper aerodigestive squamous cell carcinoma by surgeon not prepared to complete appropriate surgical therapy. | Seeding of biopsy site Altered surgical approach Unfavorably altered prognosis Increased scope of resection Increased surgical morbidity |

Conclusions

The patient with a head and neck mass presents a diagnostic challenge and an opportunity to provide appropriate and often curative treatment if the physician is knowledgeable and exercises careful diagnostic insight. There are many diagnostic options, depending on the type and location of the lesion. The physician must focus not only on the mass and its physical characteristics, but perform a thorough history and physical evaluation of all of the organ systems within the head and neck. When applied correctly, diagnostic imaging, such as CT and MRI, provide useful information. Biopsy is usually the ultimate diagnostic test leading to treatment. Fine needle aspiration biopsy may be performed safely in the primary care setting, provided that the indications for the procedure are well known and an experienced pathologist is available. Delays and pitfalls in diagnosis are best avoided by obtaining a detailed history and conducting an adequate physical, only ordering imaging to confirm or expand information from the physician's evaluation, selec-

Management of Adult Head and Neck Masses

tively applying biopsy procedures, and timely use of head and neck surgical consultation.

References

1. DeWeese DD, Saunders WH, Schuller DE, Schleuning AJ. *Otolaryngology — Head and Neck Surgery*. 7th ed. St. Louis: CV Mosby; 1988:329-331.
2. McGuirt WF. Neck masses: differential diagnosis and therapeutic approach. In: Shockley WW, Pillsbury HC, eds. *The Neck: Diagnosis and Surgery*. St. Louis: Mosby; 1994:73-89.
3. Johns ME, Harris AE. *Salivary Gland Tumors: Therapy Based on Clinical-Pathologic Diagnosis*. 2nd ed. Washington, DC: American Academy of Otolaryngology-Head and Neck Surgery Foundation, Inc; 1985:1-62.
4. Spiro RH, Spiro JD. Cancer of the salivary glands. In: Myers EN, Suen JY, eds. *Cancer of the Head and Neck*. 2nd ed. New York: Churchill-Livingstone; 1989:645-668.
5. Joe VQ, Westesson P. Tumors of the parotid gland: MR imaging characteristics of various histological types. *AJR*. 1994;163:433-438.
6. Sessions RB, Diehl WL. Thyroid cancer and related nodularity. In: Myers EN, Suen JY, eds. *Cancer of the Head and Neck*. 2nd ed. New York: Churchill-Livingstone; 1989:735-790.
7. Flynn MB, Poppelwell BA, Moore C. Anatomic location and variety of nonmalignant neck masses seen in surgical practice. *Am Surg*. 1991;57:451-453.
8. Curtin HD, Tabor EK. Radiologic evaluation. In: Myers EN, Suen JY, eds. *Cancer of the Head and Neck*. 2nd ed. New York: Churchill-Livingstone; 1989:39-74.
9. DeMarino DP, Mueller DP, Maves MD, et al. Multiple paragangliomas. *Ann Otol Rhinol Laryngol*. 1990;99:85-86.
10. Julian JS, Pittman CE, Accettullo L, et al. Does fine needle aspiration biopsy really spare patients thyroidectomy? *Am Surg*. 1989;55:238-242.
11. Suen JY. Cancer of the neck. In: Myers EN, Suen JY, eds. *Cancer of the Head and Neck*. 2nd ed. New York: Churchill-Livingstone; 1989:221-254.

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Treatment of Pneumothorax in the Patient with AIDS

Carolyn E. Becker, MD; Mark Reynolds, MD; Thomas M. Roy, MD

With the diagnosis of the adult immunodeficiency syndrome (AIDS), a patient's risk of sustaining a nontraumatic pneumothorax increases to 450 times that of the general population.¹ The approach to pneumothorax that occurs in the patient with AIDS differs from the strategy that is used for spontaneous pneumothorax in immunocompetent young adults. The modifications in treatment are predicated on understanding the etiology of spontaneous lung collapse in the patient with AIDS.

Although several opportunistic lung infections are associated with pneumothorax, 95% of AIDS patients with spontaneous lung collapse have active infection with *Pneumocystis carinii* at the time of presentation. This association is so strong that the three major risk factors for spontaneous pneumothorax in an AIDS patient are, (1) active pneumonia due to *P carinii*, (2) a prior history of PCP, and (3) history of receiving aerosolized pentamidine isethionate.²

More than 80% of patients with AIDS will suffer from *P carinii* pneumonia at some time during their life. As a result of this infection, approximately 10% of patients with AIDS will have evidence of pneumatoceles on standard chest radiographs.³ When imaging of the chest is conducted by computed tomography, premature bullous damage can be documented in up to 40% of patients with AIDS.⁴ These subpleural lesions may rupture spontaneously, especially during episodes of coughing, and lead to spontaneous pneumothorax.

The pneumatoceles appear to behave like the cystic changes attributed to an infectious process. In the patient with AIDS, the parenchymal lung destruction and pneumatoceles are histologically linked to infection with *P carinii*. The cysts are thin-walled with no intracystic material, yet are frequently lined with *Pneumocystis* organisms. During an active infection with *P carinii*,

these pneumatoceles show no predilection for a particular area of the lung. With eradication of the PCP infection, the pneumatoceles usually resolve in about 7 months.⁶

Parenchymal cavitation and cystic lesions tend to occur more often in the upper lobes near the pleura when nebulized pentamidine is used as prophylaxis against recurrent *Pneumocystis* infection. In this situation, the inhaled medication deposits primarily in the lower lobes, leaving the upper lobes with less protection. Should infection develop despite prophylaxis, the chest radiograph can show predominant involvement of the upper lobes instead of the characteristic diffuse bilateral infiltrates. Prophylactic treatment with nebulized pentamidine isethionate, while not a direct cause of barotrauma, should alert the clinician to the possibility of the development of apical bullae.⁷

Overall, it is estimated that 2% of patients with AIDS will develop pneumothoraces unrelated to trauma or pulmonary procedures.⁸ If only patients with AIDS and *Pneumocystis* infection are considered, the incidence increases to 9%.⁹

When spontaneous pneumothorax occurs in a patient with AIDS, there is a high probability that there is peripherally sequestered active infection by PCP. The inference is that the patient will need more than just lung re-expansion for a successful outcome. Favorable results will also depend on successful treatment of the underlying infection. An increase in morbidity and complications of treatment can be attributed to the patient's immunosuppression and decreased healing ability. The pneumothorax-related mortality is cited as 10%.⁸ A more aggressive standardized approach to this problem may benefit the patient with AIDS.

Case Presentation

A 29-year-old male intravenous drug user was admitted to the VAMC for dyspnea. Two weeks earlier, he had experienced sudden onset of short-

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Treatment of Pneumothorax in AIDS

ness of breath and right sided chest pain. He was examined at an outlying emergency facility and a chest radiograph was performed. He was told that he had a 15% to 20% pneumothorax. He was advised to return home and rest, as the size of the pneumothorax was small and no intervention was warranted. He was advised to see his family doctor if the shortness of breath became worse. The shortness of breath continued over the next 2 weeks until he presented to the VAMC for re-evaluation.

The patient had tested positive for antibodies to HIV 12 months earlier when he was hospitalized and treated for a diffuse bilateral pneumonia due to *Pneumocystis carinii*. Symptomatic and radiographic improvement followed therapy. He was enrolled in a clinic that provided him with aerosolized pentamidine once a week. He was also provided daily zidovudine.

Physical examination confirmed that breath sounds were diminished in the right hemithorax. Tactile fremitus was absent and percussion was hyperresonant when compared to the left hemithorax. The patient was tachycardiac with heart rate of 110 beats per minute. The remainder of the exam was unremarkable.

Chest radiograph showed a 60% pneumothorax on the right side. A chest tube was inserted but the lung failed to re-expand without suction. Gradual increases in suction to 25 cm of water were needed to accomplish re-expansion. Due to continued leak, a pleuroscopic examination was performed and two apical blebs were stapled. Talc pleurodesis was performed after complete inspection of the visceral pleura. Samples of pleura sent to the laboratory contained *P carinii*. Five days after the procedure, the patient was discharged without evidence of recurrence of his pneumothorax.

Discussion

Without appropriate treatment, the incidence of recurrence of lung collapse in the AIDS patient is about 65%. The lesions that allow lung rupture are generally multiple and involve intraparenchymal necrosis in both lungs. The widespread pockets of necrosis explain the frequency of spontaneous bilateral lung collapse in the AIDS patient. Not surprisingly, patients with bilateral pneumothoraces have more extensive disease. Their average survival is only 2 months.¹⁰

Early efforts in the treatment of pneumothorax in the AIDS patient demonstrated that perma-

nent lung re-expansion could not reliably be accomplished by simple tube thoracotomy probably due to the multiple sites of parenchymal necrosis along the periphery of the lung. When conventional drainage therapy alone is used in the AIDS patient, the in-hospital mortality ranges from 10% to 30%, compared to 1% to 2% mortality for immunocompetent patients with pneumothorax.¹¹

Early pleurodesis with an agent that can cause pleural inflammation is uniformly recommended.¹² This is usually achieved with the instillation of a tetracycline analog such as doxycycline through the chest tube into the pleural space. Usually, 100 to 300 mg of lidocaine is instilled for local anesthesia. This is followed by instillation of 500 mg of doxycycline mixed in 30 ml of sterile saline. The mixture is allowed to dwell in the pleural space for approximately 2 to 3 hours. The tube is then unclamped and returned to gravity drainage with water seal. Additional administration of analgesics is often necessary.

When tetracycline pleurodesis is not effective, some investigators recommend talc sclerosis.¹³ The recurrence rate following successful sclerotherapy with either agent is not known, since the majority of patients die with AIDS-related problems unrelated to their pneumothorax or pleurodesis. Talc solution is more difficult to instill into the pleural space through a chest tube, and the use of doxycycline remains the clinician's first choice at the bedside.

Spontaneous pneumothorax in patients with AIDS may be refractory to closed pleurodesis and may cause continued air leak with inability to fully expand the lung. The morbidity of developing a bronchopleural fistula with prolonged chest tube drainage was documented in 14 of 44 patients.¹⁴ Patients who need chest tubes for longer than 5 to 7 days benefit from early surgical intervention. The operative mortality is acceptable for early surgical procedures, but increases to approximately 14% if surgery is delayed until a bronchopleural fistula must be closed.¹⁵

Video-assisted thoracoscopy has been the most effective method of surgical treatment. It allows percutaneous entry into the pleural space to perform stapling of blebs, parietal pleurectomy, and/or the insufflation of talc.¹⁶ When coupled with a high resolution CT scan to localize and characterize the lesions, the procedure is associated with only a 0.5% recurrence rate for pneumothorax. Its utility is limited, however, by the patient's underlying condition. It requires ade-


quate clotting parameters and a patient that can tolerate selective intubation, single lung ventilation, and general anesthesia.¹⁷

If the patient is unable or unwilling to undergo thoracoscopy, the clinician must recognize that a large bore chest tube is prone to complication with bronchopleural fistula. In this situation, it has been suggested that the patient be provided with a small chest catheter attached to a one-way Heimlich flutter valve. The patient may then be ambulatory, return home, and be re-evaluated for thoracoscopy if his condition improves.¹⁸

In summary, the AIDS patient with pneumothorax also has an active focus of infection that prevents long-term success with conventional closed chest tube therapy for lung re-expansion. Early pleurodesis to obliterate the pleural space is mandatory to avoid treatment complications and recurrence. If chemical pleurodesis cannot be accomplished within 5 to 7 days, the patient should be evaluated by the thoracic surgeon for percutaneous video-assisted pleurectomy and talc insufflation. Continued use of a chest tube for longer periods is associated with increased morbidity for bronchopleural fistula and increased mortality.

References

1. Truitt T, Bagheri K, Safirstein BH. Spontaneous pneumothorax in *Pneumocystis carinii* pneumonia: common or uncommon? *AJR*. 1992;158(4):916-917.
2. Read CA, Reddy VD, O'Mara TE. Doxycycline pleurodesis for pneumothorax in patients with AIDS. *Chest*. 1994;105(3):823-825.
3. Sandhu JS, Goodman PC. Pulmonary cysts associated with *Pneumocystis carinii* pneumonia in patients with AIDS. *Radiology*. 1989;173(1):33-35.
4. Kuhlman JE, Knowles MC, Fishman EK, Siegelmen SS. Premature bullous pulmonary damage in AIDS: CT diagnosis. *Radiology*. 1989;173(1):23-26.
5. Beers MF, Sohn M, Swartz M. Recurrent pneumothorax in AIDS patients with *Pneumocystis pneumonia*. A clinicopathologic report of three cases and review of the literature. *Chest*. 1990;98(2):266-270.
6. Chow C, Templeton PA, White CS. Lung cysts associated with *Pneumocystis carinii* pneumonia: radiographic characteristics, natural history, and complications. *AJR*. 1993;161(3):527-531.
7. Shanley DJ, Luyckx BA, Haggerty MF, Murphy TF. Spontaneous pneumothorax in AIDS patients with recurrent *Pneumocystis carinii* pneumonia despite aerosolized pentamidine prophylaxis. *Chest*. 1991;99(2):502-504.
8. Sepkowitz KA, Telzak EE, Gold JW, et al. Pneumothorax in AIDS. *Ann Intern Med*. 1991;114(6):455-459.
9. McClellan MD, Miller SB, Parsons PE, Cohn DL. Pneumothorax with *Pneumocystis carinii* pneumonia in AIDS. Incidence and clinical characteristics. *Chest*. 1991;100(5):1224-1228.
10. Renzi PM, Corbeil C, Chasse M, Braidy J, Matar N. Bilateral pneumothoraces hasten mortality in AIDS patients receiving secondary prophylaxis with aerosolized pentamidine. *Chest*. 1992;102(2):491-496.
11. Wait MA, Estrera A. Changing clinical spectrum of spontaneous pneumothorax. *Am J Surg*. 1992;164(5):528-531.
12. Feurestein IM, Archer A, Pluda JM, et al. Thin-walled cavities, cysts, and pneumothorax in *Pneumocystis carinii* pneumonia: further observations with histopathologic correlation. *Radiology*. 1990;174:697-702.
13. Tunon de Lara JM, Constans J, Vincent MP, Receveur MC, Conri C, Taytard A. Spontaneous pneumothorax associated with *Pneumocystis carinii* pneumonia. Successful treatment with talc pleurodesis. *Chest*. 1992;101(4):1177-1178.
14. Crawford BK, Galloway AC, Boyd AD, Spencer FC. Treatment of AIDS-related bronchopleural fistula by pleurectomy. *Ann Thorac Surg*. 1992;54(2):212-214.
15. Horowitz MD, Oliva H. Pneumothorax in AIDS patients: operative management. *Ann Surg*. 1993;59(3):200-204.
16. Kimmel RD, Karp MP, Cascone JJ, Zinns JS. Talc pleurodesis during videothoracoscopy for *Pneumocystis carinii* pneumonia-related pneumothorax. A new technique. *Chest*. 1994;105(1):314-315.
17. Feins RH. The role of thoracoscopy in the AIDS/immunocompromised patient. *Ann Thorac Surg*. 1993;56(3):649-650.
18. Driver AG, Peden JG, Adams HG, Rumley RL. Heimlich valve treatment of *Pneumocystis carinii* associated pneumothorax. *Chest*. 1991;100:281-282.



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Development of a Statewide Trauma System:

Classification of Levels of Care Available to Injured Patients

J.E. Svenson, MD; J.S. Stopczynski, MD; M. Nypaver, MD; R. Calhoun, MPH

OBJECTIVE: To categorize the level of care offered in emergency settings at acute care hospitals in Kentucky.

DESIGN: Survey mailed to all hospitals in the state.

MEASUREMENTS/MAIN RESULTS: Hospital capabilities for both adult and pediatric patients were assessed by strict adherence to a set of preset objective requirements and by a subjective review of the resources available to the acutely injured patient, based on the responses to a mailed questionnaire.

There are three level 1 and nine level 2 hospitals available to adults and two level 1 and seven level 2 hospitals available to children in Kentucky. Thirty-five counties are without an acute care hospital. Objective- and subjective-based classification were discordant in approximately 25% of hospitals. Current referral patterns reflect this categorization, but referral is most often directly to level 1 centers. **CONCLUSIONS:** We have established a set of criteria to categorize the level of care acutely available to injured patients in Kentucky which can be simply implemented. In developing statewide systems of care, strict adherence to preset criteria may not accurately reflect the true resources available. With the lack of a planned and organized system, current referral patterns reflect transfer of patients directly to level 1 centers, which may result in overtriage and underutilization of level 2 or level 3 hospitals.

The presence of a trauma center in a region has been associated with lower death rates.¹² Treatment at trauma centers reduces mortality compared to treatment at full-service community hospitals.²² Trauma systems are developed to address the needs of all injured patients.⁶ Trauma systems have been shown to reduce mortality and morbidity from injuries.^{4, 13, 16, 20} Because of the need for training and equipment relevant to children, the needs of pediatric patients and regionalization of pediatric care has often been considered separately, though the outcome of children treated at adult trauma centers is comparable to outcome in pediatric trauma centers.^{5, 7, 9, 29, 30} Trauma systems represent an organized approach to trauma care in which patients are triaged to appropriate facilities for definitive treatment of their injuries. The American College of Surgeons (ACS) and the American College of Emergency Physicians (ACEP) have developed criteria for the designation of trauma centers and the establishment of regionalized trauma systems.^{3, 11} Despite the effectiveness of regionalized systems, implementation at the state level has been slow.^{2, 24} Calls have been made for the establishment of a nationalized trauma system, but development has likewise been slow.⁶

Designation of trauma centers and levels of care offered at non-trauma centers is necessary for effective planning, performance, and evaluation of any trauma system.^{14, 25, 26} In rural areas, trauma victims are, of necessity, initially stabilized and resuscitated at local hospitals. Urban-type systems which focus on bypass of small hospitals and direct triage to trauma centers are not feasible in these areas, because of long transport times and difficult access. In rural trauma systems, level of care categorization should focus on the ability

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Trauma is a leading cause of morbidity and mortality, especially in the young. A sizeable portion of traumatic deaths are preventable with improved prehospital and hospital care.¹⁷⁻¹⁹

Development of a Statewide Trauma System

Appendix 1: Categorization of different levels of care for adults.

| | | 1 | 2 | 3 | 4 | 5 |
|---------------------------------------------------|-----------------------------------------|---|---|---|---|---|
| Clinical Capabilities | | | | | | |
| Emergency Department | Physician present 24 hours/day | y | y | y | y | n |
| | Physician certified in ATLS | y | y | y | n | n |
| General Surgery | Physician present in-house 24 hours/day | y | y | n | n | n |
| | Physician an-call within 20 minutes | y | y | y | n | n |
| Neurological Surgery | Physician present in-house 24 hours/day | y | n | n | n | n |
| | Physician an-call within 20 minutes | y | y | n | n | n |
| Anesthesiology | Physician present in-house 24 hours/day | y | y | n | n | n |
| | Physician an-call within 20 minutes | y | y | y | n | n |
| Orthopedics | Physician an-call within 20 minutes | y | y | n | n | n |
| Resource Capabilities | | | | | | |
| X-Ray Technician | Present in-house 24 hours/day | y | y | y | n | n |
| | On-call within 20 minutes | y | y | y | y | n |
| CT Scanner | | y | y | y | n | n |
| CT Technician | Present in-house 24 hours/day | y | n | n | n | n |
| | On-call within 20 minutes | y | y | n | n | n |
| Laboratory Technician | Present in-house 24 hours/day | y | y | y | n | n |
| | On-call within 20 minutes | y | y | y | y | n |
| Operating Room | Available 24 hours/day | y | y | n | n | n |
| | Available, but not 24 hours | y | y | y | n | n |
| Blood Bank | 24 hours/day | y | y | y | n | n |
| ICU present | | y | y | n | n | n |
| Other | | | | | | |
| Trauma Registry | | y | n | n | n | n |
| Transfer agreements in place with other hospitals | Adults | | y | y | n | n |

Appendix 2: Categorization of different levels of care for pediatrics.

| | | 1 | 2 | 3 | 4 | 5 |
|---------------------------------------------------|-----------------------------------------|---|---|---|---|---|
| Clinical Capabilities | | | | | | |
| Emergency Department | Physician present 24 hours/day | y | y | y | y | n |
| | Physician certified in ATLS | y | y | y | n | n |
| | Physician certified in PALS | y | y | n | n | n |
| General Surgery | Physician present in-house 24 hours/day | y | y | n | n | n |
| | Physician an-call within 20 minutes | y | y | y | n | n |
| Neurological Surgery | Physician present in-house 24 hours/day | y | n | n | n | n |
| | Physician an-call within 20 minutes | y | y | n | n | n |
| Anesthesiology | Physician present in-house 24 hours/day | y | y | n | n | n |
| | Physician an-call within 20 minutes | y | y | y | n | n |
| Pediatric Surgery | Physician present in-house 24 hours/day | y | n | n | n | n |
| | Physician an-call within 20 minutes | y | y | n | n | n |
| Pediatrics | Physician present in-house 24 hours/day | y | y | n | n | n |
| | Physician an-call within 20 minutes | y | y | y | n | n |
| Orthopedics | Physician an-call within 20 minutes | y | y | n | n | n |
| Resource Capabilities | | | | | | |
| X-Ray Technician | Present in-house 24 hours/day | y | y | y | n | n |
| | On-call within 20 minutes | y | y | y | y | n |
| CT Scanner | | y | y | y | n | n |
| CT Technician | Present in-house 24 hours/day | y | n | n | n | n |
| | On-call within 20 minutes | y | y | n | n | n |
| Laboratory Technician | Present in-house 24 hours/day | y | y | y | n | n |
| | On-call within 20 minutes | y | y | y | y | n |
| Operating Room | Available 24 hours/day | y | y | n | n | n |
| | Available, but not 24 hours | y | y | y | n | n |
| Blood Bank | 24 hours/day | y | y | y | n | n |
| ICU present | | y | y | n | n | n |
| PICU present | | y | n | n | n | n |
| Other | | | | | | |
| Trauma Registry | | y | n | n | n | n |
| Transfer agreements in place with other hospitals | Adults | | y | y | n | n |
| | Pediatrics | | y | y | n | n |

of the regional hospitals to provide initial stabilization and resuscitation of trauma victims, rather than definitive care. The ACS criteria have been developed for designation of trauma centers based on total hospital capability for initial, acute treatment, and longer term, inpatient management where patients can get definitive care. Use of the ACS criteria in establishing levels of care also requires major investments in time, resources, and personnel.

As a first step in planning of a trauma system for Kentucky, we wanted to survey and categorize the level of care offered in emergency settings at acute care hospitals in the state. In order to meet this goal, we have developed a survey instrument which could be completed by hospital personnel. This paper represents the results of this survey and presents a first look at acute care capabilities throughout Kentucky.

Methods

Questionnaires were sent to the medical director of all Kentucky hospitals. These surveys included questions concerning both the medical personnel and hospital resources immediately available to care for the injured patient. A second survey letter was sent to those who did not respond to the first letter. If there was no response to either the first or second survey, attempts were made to obtain the information by telephone. No attempt was made to verify the data submitted by each hospital.

Classification criteria were set in advance and were modelled on those defined by the American College of Surgeons (Appendix).¹¹ Care offered to pediatric and adult patients was considered separately. Objective level of care offered was first determined by strictly adhering to the objective criteria. Level of care was defined as the level on which the hospital met *all* of the criteria.

Independently, hospital resources reported on the questionnaire were reviewed by two reviewers (JS, MN). A subjective level of care was assigned by those reviewers based on their review of the resources offered at the hospital. A hospital could be assigned a higher subjective level of care even if it did not strictly meet all of the objective-based criteria at that level, if the reviewers felt that the resources acutely available for patient care were equivalent. For example, an ATLS trained emergency physician and an anesthesiologist in hospital 24 hours/day were considered to meet the criteria of a surgeon in house

24 hours/day for initial patient management.

For counties with more than one hospital, the highest level of care available among those hospitals was used to categorize the county.

Results

In Kentucky there are 108 hospitals with emergency departments open 24 hours per day. Of these, responses to this survey were obtained from 93 (86%). These form the basis of this report.

For adults, there are three hospitals meeting both objective and subjective level 1 requirements within the state, located in two cities (Louisville and Lexington). There is one hospital which satisfied all objective level 2 criteria, but eight others satisfied subjective criteria as level 2 centers. Most level 2 centers are located in Lexington or Louisville. For children, there were two hospitals which met both objective and subjective criteria as level 1 centers, again located in Louisville and Lexington. There are no hospitals which meet all objective level 2 criteria for pediatric patients, however, there were seven hospitals which satisfied the subjective review as level 2 centers for children around the state. Four of these centers were located in Louisville or Lexington. The distribution of classification of hospitals is given in Table 1.

The 15 nonresponding hospitals yielded a lack of information for 14 counties within the state. Thus, of the 120 counties in the state, information for level of care was obtained for 106 (88%). There are 35 counties for which no acute care hospital is available. Thirteen of these counties are in Appalachia, while 22 are in non-Appalachian regions (Fisher's exact test $p = 0.63$). The level of care available in counties with reporting

Table 1: Level of care available in Kentucky.

| | Adults | | Pediatrics | |
|---------|--------------------|-------------------|--------------------|-------------------|
| | Objective criteria | Subjective review | Objective criteria | Subjective review |
| Level 1 | 3 | 3 | 2 | 2 |
| Level 2 | 1 | 9 | 0 | 7 |
| Level 3 | 36 | 45 | 34 | 40 |
| Level 4 | 37 | 21 | 41 | 29 |
| Level 5 | 16 | 15 | 16 | 15 |

Development of a Statewide Trauma System

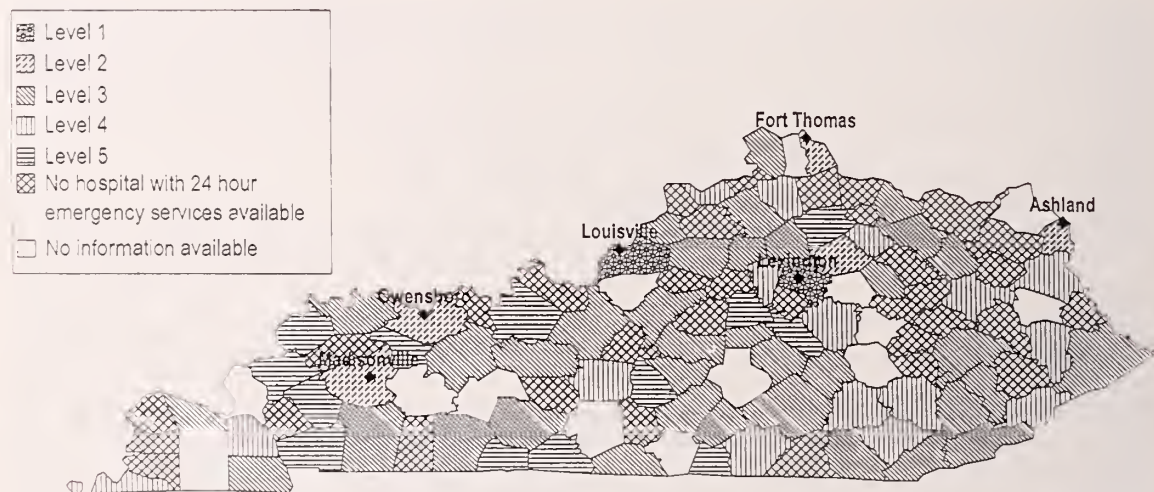


Fig 1 — Level of care available to adults.

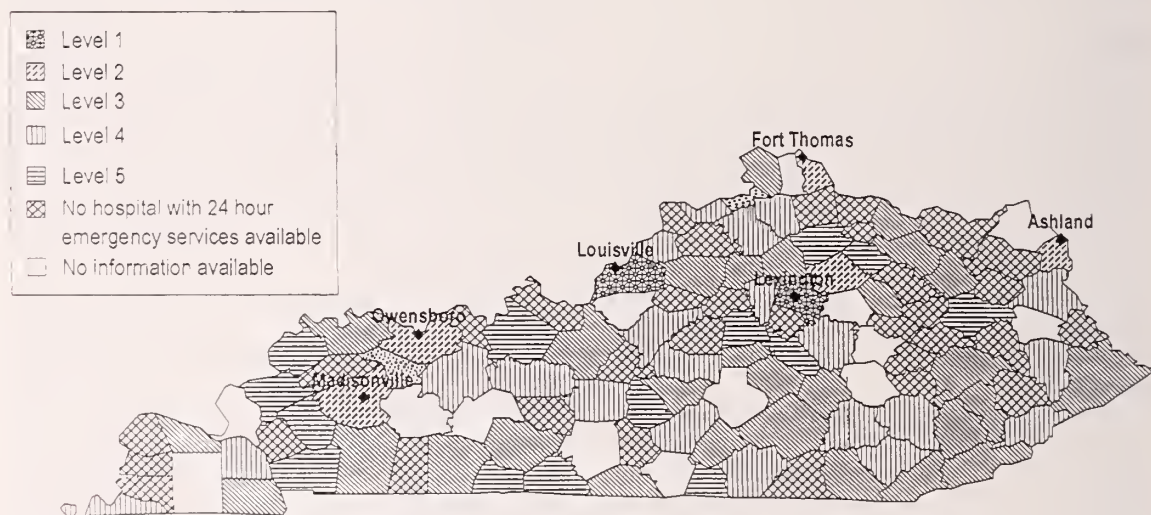


Fig 2 — Level of care available to children.

Table 2: Changes in classification using subjective review.

| Change in level | Adults | Pediatrics |
|-----------------|--------|------------|
| 2 → 1 | 0 | 0 |
| 3 → 2 | 8 | 7 |
| 4 → 3 | 17 | 13 |
| 5 → 4 | 1 | 1 |
| Total | 26 | 21 |

hospitals is shown in Figs 1 and 2. There was no difference in the relative distribution of hospital level of care offered between the Appalachian and non-Appalachian regions of Kentucky (χ^2 5df $p = 0.25$).

Subjective classification of hospitals increased the reported level of care for children at 21 (22%) hospitals within 14 counties, and level of care for adults at 26 (28%) hospitals within 21 counties. All hospitals were upgraded after review of personnel immediately available to trauma victims. Most changes in designation were from level 4 to level 3 centers (Table 2). Counties in which

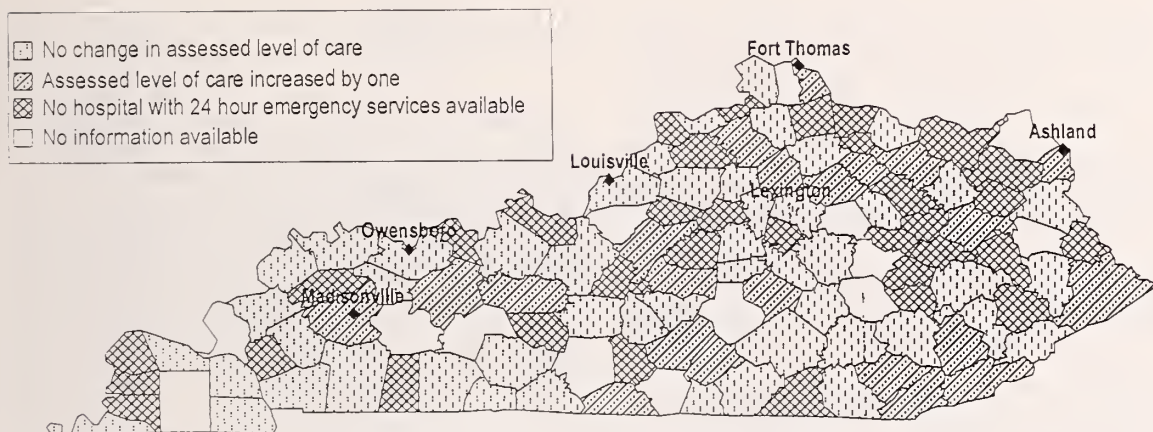


Fig 3 — Change in assessed level of care available to adults after subjective review.

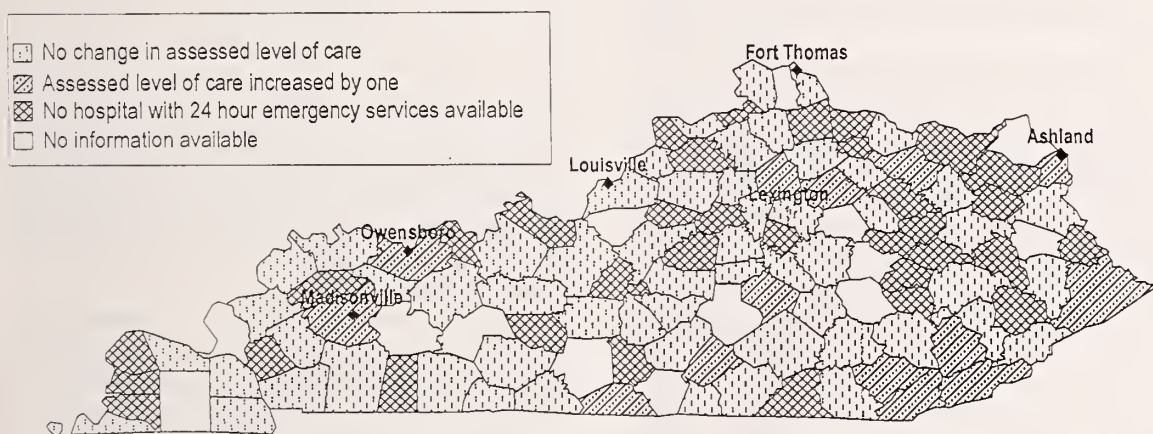


Fig 4 — Change in assessed level of care available to children after subjective review.

subjective review of classification criteria resulted in a different level of care for the county are shown in Figs 3 and 4.

Hospitals which reported referral agreements or convention usually referred to level 1 or level 2 centers. A few hospitals referred patients to level 3 centers. In no instance, when transfer conventions were reported, were patients transferred laterally to a hospital with the same designation. Border counties referred to level 1 centers in Cincinnati, Huntington, Knoxville, and Nashville (Fig 5).

Discussion

Regionalized systems of care have been reported to improve mortality and morbidity for trauma-

tized and other critically ill patients.^{1,4,10} The primary purpose of a trauma system is to deal with patients who are seriously injured or have the potential to be seriously injured. Implementation of any such system requires an evaluation of the level of care that can be offered to the acutely injured patient. This survey is a first step in assessing the resources available to residents of Kentucky. This numerical classification is not meant to be pejorative, but is a simple way of classifying levels of expertise available to injured patients.

The American College of Surgeons classification of 4 levels of care involves the resources available to in- and outpatients at each facility.¹¹ Others have used care available immediately to the patient as categorizing criteria, or using state-

Development of a Statewide Trauma System

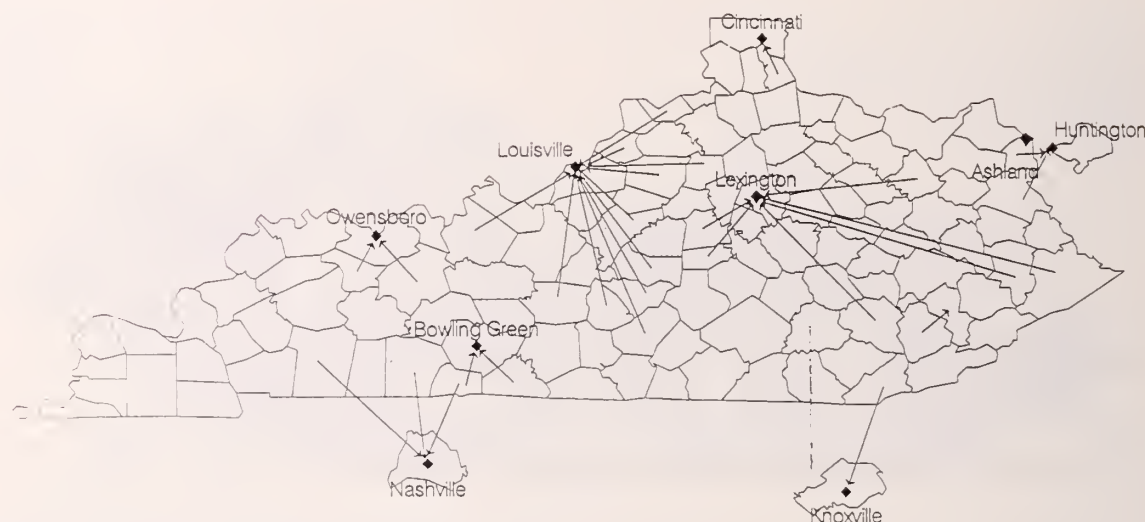


Fig 5 — Current referral patterns for Kentucky hospitals.

based criteria.^{15, 24, 27} We chose to define level of care as that which would be available to injured patients acutely and the level of expertise and evaluation accessible to them to evaluate, treat life-threatening injuries, and stabilize for transport to more definitive care institutions. These types of criteria are especially important in a rural state where trauma systems often must include an initial stabilization phase in a small hospital, rather than an urbanized system where direct transport to a trauma center bypassing smaller hospitals is feasible.^{19, 21} Large distances and transport times preclude bypass of acute care facilities in favor of direct transport to trauma centers. Timely and appropriate stabilization at small rural hospitals should be the goal of such a system, as performance of advanced diagnostic procedures at those institutions does not necessarily lead to better outcomes.^{31, 32} The criteria for pediatric designation included the availability of a pediatrician, pediatric surgeon, and an emergency physician trained in Pediatric Advanced Life Support (PALS).

Any classification system is necessarily arbitrary. We feel that our classification system makes a reasonable attempt to define care available to injured patients. While there may be some debate on the criteria which we have established, we feel that they correspond to the spirit of the ACS guidelines, without being as extensive or difficult to evaluate. Blind utilization of set criteria often classifies level of care as lower than may actually be available to patients. In addition, there are hospitals which exceed the objective-based crite-

ria at a given level, but fail to even meet that level objectively because they do not meet one criterion. For these reasons, we feel that our subjective review gives a truer look at the capabilities of hospitals in Kentucky. Such review leads to reclassification of approximately 25% of hospitals and always leads to categorizing a hospital in a higher level of care.

This classification is based on self-reported capabilities, and so may be skewed towards higher level of care than is actually available. Self designation of level of trauma care may not correspond to the ACS guidelines and not improve outcomes.³³ We did not ask participating hospitals for their assessment of their capabilities, nor did we provide copies of the classification criteria. Thus, the persons filling out the questionnaire had no knowledge of which factors were to be considered at each level of care. In addition, while this classification may be accurate in terms of the personnel and evaluative resources available to patients, there was no attempt at evaluating the actual equipment available in the emergency department for stabilization and treatment of patients, especially children.²⁸

Goals for implementation of a trauma system in a rural state such as Kentucky should include recognition of significant injuries, initial stabilization, and early transfer of patients who meet pre-established transfer criteria.¹⁵ Referral patterns will vary by hospital. The current referral patterns may mimic what would be expected in a formalized trauma system. Many hospitals already refer patients to level 1 trauma centers in Louisville

and Lexington. Hospitals at the borders refer patients to non-Kentucky trauma centers which are geographically closer.

Without a formally established trauma system with preset triage and transfer criteria, as well as system evaluation criteria, there can be no assurance that overtriage or undertriage does not occur and that critically injured patients are identified, stabilized, and transferred in a timely manner. With formal regionalization of a trauma system, cooperative triage between level 1 centers for patients with equivalent travel times might prove to be a viable alternative to fixed referral patterns.⁸

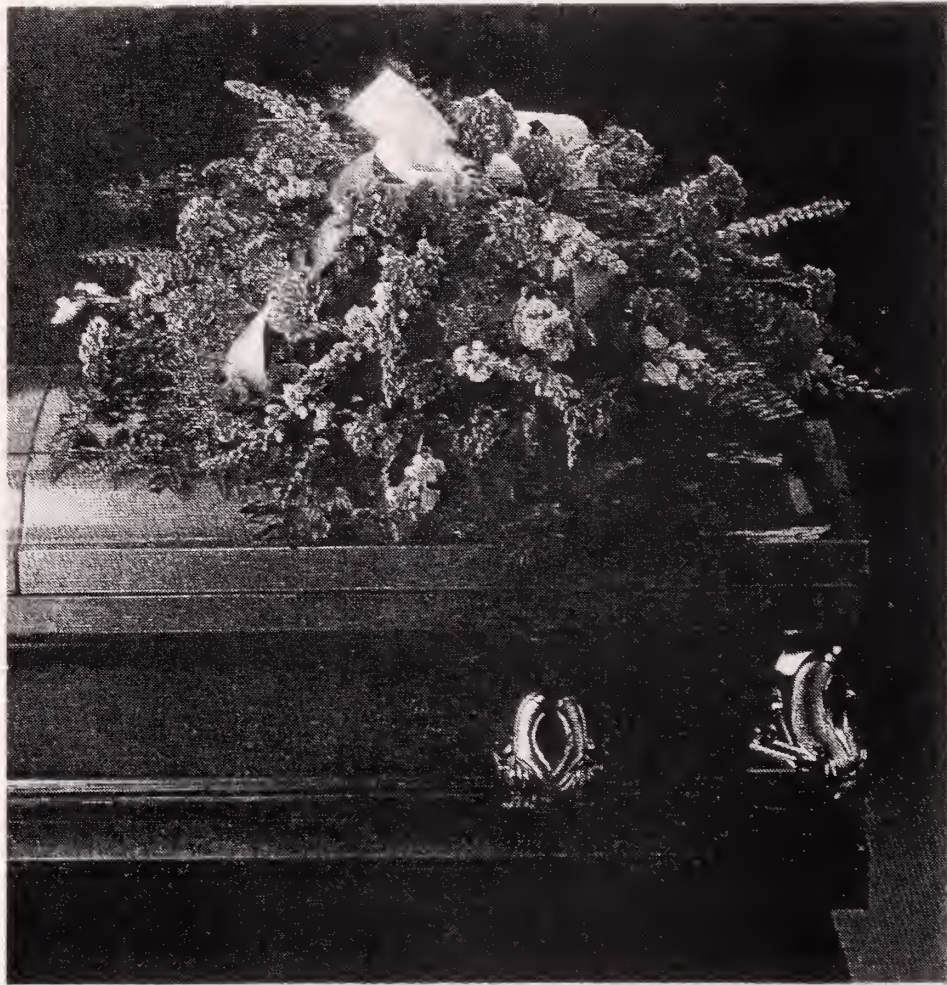
In summary, we have categorized acute care available to traumatized patients throughout the state. While these results provide no major surprises, they do serve as a first step in establishment of a regionalized system of care which would optimize outcomes for severely injured patients.

Author's Note: Further information received since this paper went to press would increase the subjective level of care offered to adults to level 2 in Boone County. Thus, there are ten level 2 centers for adults located around the state.

References

1. Jastremski MS. Regionalization and categorization of critical care services. *Crit Care Clin*. 1993;9:603-612.
2. Mendeloff JM, Cayten CG. Trauma systems and public policy. *Ann Rev Publ Health*. 1991;12:401-424.
3. American College of Emergency Physicians. Guidelines for trauma care systems. *Ann Emerg Med*. 1993;22:1079-1100.
4. Mullins RJ, Veum-Stone J, Helfand M, et al. Outcome of hospitalized injured patients after institution of a trauma system in an urban area. *JAMA*. 1994;271:1919-1924.
5. Pollack MM, Alexander SR, Clarke N, et al. Improved outcomes from tertiary center pediatric intensive care: A statewide comparison of tertiary and nontertiary facilities. *Crit Care Med*. 1991;19:150-159.
6. Third National Injury Control Conference. Position paper on trauma care systems. *J Trauma*. 1992;32:127-129.
7. Yeh TS. Regionalization of pediatric critical care. *Crit Care Clin*. 1992;8:23-35.
8. Pagliarello G, Dempster A, Wesson D. The integrated trauma program: A model for cooperative trauma triage. *J Trauma*. 1992;33:198-203.
9. Teres D, Lieberman S. Are we ready to regionalize pediatric intensive care? *Crit Care Med*. 1991;19:139-140.
10. West JG, Cales RH, Cazzaniga AB. Impact of regionalization. *Arch Surg*. 1983;118:740-744.
11. Committee on Trauma. Resources for optimal care of the injured patient. Chicago, American College of Surgeons, 1993.
12. Rutledge R, Messick J, Backer CC, et al. Multivariate population-based analysis of the association of county trauma centers with per capita county trauma death rates. *J Trauma*. 1992;33:29-38.
13. Kane G, Wheeler NC, Cook S, et al. Impact of the Los Angeles County trauma system on the survival of seriously injured patients. *J Trauma*. 1992;32:576-583.
14. MacKenzie EJ, Steinwachs DM, Ramzy AI. Evaluating performance of statewide regionalized systems of trauma care. *J Trauma*. 1990;30:681-688.
15. Hedges JR, Mullins RJ, Zimmer-Gembeck MJ, Helfand M, Southard P. Oregon trauma system: Change in initial admission site and postadmission transfer of injured patients. *Acad Emerg Med*. 1994;1:218-226.
16. Shackford SR, Hollingworth-Fridlund P, Cooper GF, et al. The effect of regionalization upon the quality of trauma care as assessed by concurrent audit before and after institution of a trauma system: A preliminary report. *J Trauma*. 1986;26:812-820.
17. Roy PD. The value of trauma centers: A methodologic review. *Can J Surg*. 1987;30:17-22.
18. Lowe DK, Gately HL, Goss JR, et al. Patterns of death, complication, and error in the management of motor vehicle accident victims: Implications for a regional system of trauma care. *J Trauma*. 1983;23:503-509.
19. Cales RH, Trunkey DD. Preventable trauma deaths: A review of trauma care systems development. *JAMA*. 1985;254:1059-1063.
20. Cales RH. Trauma mortality in Orange County: The effect of implementation of a regional trauma system. *Ann Emerg Med*. 1984;13:1-10.
21. Cales RH, Anderson PG, Heilig RW. Utilization of medical care in Orange County: The effect of implementation of a regional trauma system. *Ann Emerg Med*. 1985;14:853-857.
22. Clemmer TP, Orme JF, Thomas FO, et al. Outcome of critically injured patients treated at level 1 trauma centers versus full-service community hospitals. *Crit Care Med*. 1985;13:861-865.
23. Shackford SR, MacKersie RC, Hoyt DB, et al. Impact of a trauma system on outcome of severely injured patients. *Arch Surg*. 1987;122:523-527.
24. Aprahamian C, Wolferth C, Darin C, McMahon JC, Weitzel-DeVeas J. Status of trauma center designation. *J Trauma*. 1989;29:566-570.
25. Eastman AB, Lewis F, Champion H, Mattox F. Regional trauma system design: Critical concepts. *Am J Surg*. 1987;154:79-87.
26. West JG, Williams MJ, Trunkey DD, Wolferth CC. Trauma systems: Current status-future challenges. *JAMA*. 1988;359:3600.
27. Fifield GC, Magnuson C, Carr WP, Deinard AS. Pediatric emergency care in a metropolitan area. *J Emerg Med*. 1984;1:495-507.
28. Zaritsky A, French JP, Schafermeyer R, Morton D. A statewide evaluation of pediatric prehospital and hospital emergency services. *Arch Pediatr Adolesc Med*. 1994;148:76-81.
29. Knudson MM, Shagoury C, Lewis FR. Can adult trauma surgeons care for injured children? *J Trauma*. 1992;32:729-737.
30. Fortune JB, Sanchez J, Graca L, et al. A pediatric trauma center without a pediatric surgeon: a four-year outcome analysis. *J Trauma*. 1992;33:130-137.
31. Kearney PA, Terry L, Burney RE. Outcome of patients with blunt trauma transferred after diagnostic or treatment procedures or four-hour delay. *Ann Emerg Med*. 1991;20:882-886.
32. Thoburn E, Norris P, Flores R, et al. System care improves trauma outcome: Patient care errors dominate reduced preventable death rate. *J Emerg Med*. 1993;11:135-139.
32. Campbell S, Watkins G, Kreis D. Preventable deaths in a self-designated trauma system. *Am Surg*. 1989;55:478-480.

He beat her 150 times. She only got flowers once.



Every 15 seconds, a woman is beaten in this country.
For as many as four million women, this battering is so severe, they require
medical or police attention.

But for nearly 4,000 women each year, the abuse ends. They die.

National Coalition Against Domestic Violence
P.O. Box 18749, Denver, CO 80218-0749, (303) 839-1852

When A History of Physical Abuse Is License for Societal Abuse

In many states insurers have begun to use a history of physical abuse as an underwriting criterion for denial of issuance or renewal of health, life, disability, homeowners, and car insurance.

These overwhelmingly predominantly female victims of violent crime are essentially criminalized a second time. Moreover, when this history is used to deny these women these forms of insurance, in many instances this amounts to denying them a way out of their cyclically violent lives. No health insurance for themselves and their children means no way to care for children outside of their dysfunctional relationship. No car insurance means no car and no means of transportation to escape or to obtain a job. No home insurance often means no buying or even renting a home.

"This is a blatant form of discrimination against women with immediate and devastating effects. And, as physicians, we are unwitting parties to it all."

Clearly, being beaten by someone one knows is considered a pre-existing condition in the eyes of these insurers. In Kentucky, as of January 1996, by law no "pre-existing condition" may preclude the issuance of health insurance. But, nothing precludes our medical records being used to adversely affect the rest of a

patient's insurance needs, and, therefore, their life.

The tradition of patients signing "blanket" authorizations for release of medical records for insurance purposes means that information pertinent to abuse is often released without consideration in instances where it does not appear to be germane. However, these records are then specifically screened for this factor, and, when present, used to deny unrelated insurance.

As Kentucky physicians, we are bound by law to document and report known and suspected incidents of abuse. And yet the very presence of this concern in our records could turn these already victimized women's lives upside down yet again. A law which seeks to enhance the ease of reaching and helping these women escape dysfunctional lives may provide the very mechanism through which their means of escape is removed.

While now this is a problem of varying degree in different states, *AMA News* reported in its November 4, 1995, issue that insurance companies accounting for 99% of individual life insurance policies and 80% of health and disability policies in the US belong to a computerized information exchange database service, the Medical Information Bureau Exquifax. Member companies are required to report risk factors. If the existence of the problem alone is currently startling, the potential for spread of the problem through use of this database is staggering. Moreover, insurers avail themselves to so-called "public records" of otherwise intimate private proceedings of court records, credit, and employment records.

This is a blatant form of

discrimination against women with immediate and devastating effects. And, as physicians, we are unwitting parties to it all.

"In Kentucky, as of January 1996, by law no 'pre-existing condition' may preclude the issuance of health insurance. But, nothing precludes our medical records being used to adversely affect the rest of a patient's insurance needs, and, therefore, their life."

The legal mandate to report is designed to set into motion helpful mechanisms for these women to get help, medical care, counseling, and maybe even break out of the cycle. We could divide medical records release authorizations and our charts so that our attempts to help these women don't result in still greater destructive actions of discrimination directed towards them. We can support any thoughtful state or national legislative attempt to criminalize these actions and penalize those responsible. But, channels for legal redressing of discrimination move slowly, and so, in the interval, physicians must be aware of yet another Catch-22 affecting our lives and actions and those for whom we pledge above all to do no harm.

Martha K. Heyburn, MD

Medicare and Medicaid Reductions

A recent article in the *Lexington Herald Leader*, November 4, 1995, raised alarms about the possibility that reductions in Medicare and Medicaid spending might increase cost shifting to the private sector.

It is unfortunate that there is a perception that the provision of medical care has become so inflexible in the face of the very same economic forces that every other institution must face.

Physicians should fight this perception. Medical care can be more efficient and it is in the best interest of the profession of physicians to do so; because, otherwise, it will be done to us.

Medical care can have improved efficiency, but it depends on the recognition of what, at least to me, seemed very straight forward principles:

1. Legal and regulatory reform to end the practice of defensive medicine.
2. Ending restrictions of Medicare billing: Historically, one of the most important functions of physicians in society was to charge the "rich" more in order to pay for the care of the "poor." If the government has sought to take this privilege away from physicians, it is neither accidental nor without very significant and far reaching consequences for the profession.
3. Patients should be personally responsible for at least a portion of their medical bill pay for more of their own medical care: this will limit fraud and hopefully, limit

bureaucratic meddling.

4. Empower the physicians: Strangely, the individual physician feels increasingly powerless to cope with the organized assault on his prerogatives; organized medicine must respond to this challenge.

Doctors are being blamed for the high costs of medical care even though much of these costs are related to a tremendous growth in medically-related employment. This growth of employment has had very salutary effects on the general economy; as far as for the individual physician, however, it is not clear to me that it has made much of a difference though physicians have invested a great deal of their own personal time in managing and directing this growth of employment, mostly without direct remuneration to themselves.

The impression I get from the politicians is that they very much want to maintain this high rate of medical employment; however, they also wish to cut the overall costs of medical care. To me, these are mutually irreconcilable goals, however, I suspect that the idea is out there that physicians are simply going to take the brunt of these cuts.

I personally do not believe this is a wise policy; the true course of increasing efficiency lies ultimately in innovations that will come from doctors who are able to do more with less; the only way to accomplish this, from the standpoint of economic incentives, is to increase the reimbursement for this feat rather than the other way around. I believe that this is a worthwhile policy goal for organized medicine; I suspect that the incentives present in the HMO approach to medical care are insufficient to achieve this result.

When I started in medical

practice, my wife was my secretary and I worked with a retired nurse. My overhead was minuscule; I don't know why doctors are supposed to both reduce their charges and, at the same time, employ large office staffs.

F. Andrew Morfesis, MD

Preventing Death From Anaphylactic Reaction

Thousands of deaths are needless. Why are they needless?

1. Because of a lack of education concerning the use of epinephrine (adrenaline) that can be used in the case of a reaction to an insect sting to prevent death in the event of anaphylactic reaction.
2. The failure of states to pass legislation to allow laymen to administer epinephrine.

I have worked to educate laymen and get laws passed in states to allow laymen to administer epinephrine. Everyone should have an emergency epinephrine kit. As a lone crusader, I have been able to get legislation passed in 20 states.

Death from severe anaphylactic reaction can occur in five minutes, which is insufficient time to get to medical aid. Doug Milner was unconscious within minutes. Epinephrine (adrenaline) is the only treatment that will save a person suffering an anaphylactic reaction.

Claude A. Frazier, MD
Doctors Park, Bldg 4
Asheville, NC 28801

China

As President-Elect of the KMA Alliance, in my first article for the *KMA Journal*, I wish to share with you an unparalleled experience in China and Hong Kong. In November 1995, I was privileged to accompany my husband on a CME trip to Shanghai, Beijing, Guilin, and Hong Kong where we were fortunate to observe in a modest way the practice of western versus traditional medicine.

Dr W. Huang, a cardiologist and director of the Shanghai hospital we visited, trained at the University of Alabama Birmingham; he informed us that there is no similarly structured residency program in China. While a medical school graduate may state his preference of a specialty, he usually must apprentice in the area needed at that time by the hospital in which he works.

Dr Yu Ting, an immunologist and director of the Beijing hospital we visited, trained at Duke University and Iowa State University; he informed us that there are practically no medical problems related to alcohol or violence; there are 1500 documented cases of AIDS in the country, with 150 confirmed deaths. Infectious diseases are still a major problem due to unsanitary conditions in many areas. They do have open heart surgery and

“...there are practically no medical problems related to alcohol or violence; there are 1500 documented cases of AIDS in the country, with 150 confirmed deaths.”

renal dialysis but no bypass surgery; there are no organ transplants because there are no donors. The Chinese traditional medicine we observed included acupuncture and herbal medication.

On balance, the Chinese, a hard-working, honest people, are making strides in medical expertise through education and the use of the latest technological equipment.

Everything in China is influenced by the number of people, 1.2 billion. Cities are more populous than we had imagined, such as 14 million in Shanghai, 8 million in Beijing, and 6 million in Xian. The *long* history of China determines its remarkable present and future; from the 21st century B.C.; through the Qing dynasty, so aptly portrayed in the movie *The Last Emperor*; the Japanese occupation 1931-45; the struggle between the Nationalists and the Communists, resulting in Chiang Kai Shek's flight to Taiwan in 1949; Mao's particular style of leadership 1949-76; the 1972 Shanghai Joint Communique, normalizing bilateral relations between the United States and China; the Cultural Revolution of 1966-76, an enigmatic attempt to repudiate all traditional values; reforms instituted since 1978, especially manifest in the economic arena — *Joint Venture* is the watchword of the '90s! Two of the most impressive historical treasures are the 3700 mile-long Great Wall and the approximately 8000 life-size terracotta warriors and horses protecting the tomb of the First Emperor, Qin, after whom we call the country China. The Chinese call their country Zhongguo, Middle Kingdom (of the world).

Hong Kong has immense wealth! There are 140 banks facilitating tremendous trade between oriental



Ruth Ryan

“On balance, the Chinese, a hard-working, honest people, are making strides in medical expertise through education and the use of the latest technological equipment.”

and occidental countries. We are living in historical times; on July 1, 1997, China is to take back from the British: Hong Kong, Kowloon, and the New Territories. In Beijing's Tiananmen Square there is a huge digital clock ticking to the second that momentous event! It will be interesting to monitor the 1984 Hong Kong Agreement between China and Britain which stipulates that China honor the special status of Hong Kong for 50 years, allowing a free market economy, freely convertible Hong Kong dollar, free education, freedom of travel, press, and religion.

Ruth Ryan
KMAA President-Elect

KMA Board of Trustees — December Meeting



The KMA Board of Trustees met on December 13-14, 1995, at the Oxmoor Country Club in Louisville. The Board members heard routine reports of the President; Secretary-Treasurer; Senior Delegate to AMA; Alliance President; Associate Dean, University of Louisville School of Medicine; Chair, KEMPAC Board of Directors; Commissioner for Health Services; and the Board of Medical Licensure.

A special presentation was given by representatives of KMIC regarding its merger with Michigan Physicians Mutual Liability Company.

Detailed reports were given on activities of the Joint Oversight Group on Health Care Reform and the Committees on National and State Legislative Activities.

Appointments were made to the KMIC Board, and selections were made for submission to the Governor for appointments to the Hemophilia Advisory Board and the Kentucky Tobacco Research Board.

In further action, the Board adopted mission statements for the newly appointed Statewide Health Information Network Feasibility Study Committee and the Interspecialty Council. In response to Reference Committee No. 4, the Board recommended that the Health Policy Board set up an insurance ombudsman for patients to contact for unresolved problems with their insurance company or HMO.

Legal Counsel updated the Board on current legal activities during an executive session.

Additional reports were given by the Committee on Public Education, the KMA Hospital Medical Staff Section, and the Physician Organization Study Committee. In addition, a membership report was presented.

It was noted that the 1996 Annual Meeting will be held in Louisville with the new weekend format. The theme for the 1996 meeting is "Quality Care in an Age of Efficiency."

The next meeting of the KMA Board of Trustees was scheduled for April 17-18, 1996, at the Oxmoor Country Club.



Top photo — Board members, L to R, Harry W. Carloss, MD, Chair; Danny M. Clark, MD, President; C. Kenneth Peters, MD, Speaker; William H. Mitchell, MD, President-Elect; Mark F. Pelstring, MD, 8th District Trustee; Donald R. Stephens, MD, Vice President.

Bottom left — G. Irene Minor, MD, 11th District Trustee, shared her views with the Board.

Bottom right — President Clark received a Journal plaque from Executive VP Robert G. Cox (L).



Tap left — President Clark and President-Elect Mitchell listened intently to the proceedings.

Tap right — Secretary-Treasurer William P. VonderHaar, MD, emphasized his perspective on a topic of discussion.

Center — William B. Mannig, MD, attracted the undivided attention of his colleagues as he discussed the issues. Dr Mannig is a KMA Past President and currently serves as an AMA Alternate Delegate. Surrounding Dr Mannig L to R were 10th District Alternate Trustee Andrew R. Pulita, MD, (in background); 15th District Trustee Paul R. Smith, MD (back to camera); AMA Senior Delegate Danald C. Bartan, MD, Carbin; 2nd District Trustee Danald R. Neel, MD (behind Dr Mannig); and newly elected 4th District Trustee Eugene H. Shively, MD.



Bottom — E. D. Roberts, MD, 14th District Trustee, gestured to impress a point during his comments. Seated behind Dr Roberts were Dr Irene Minar and KMAA President Marla Vieillard.

PEOPLE

Rudy J. Ellis, MD, has received the National Interscholastic Athletic Administrators Association Distinguished Service Award. This award recognizes someone who is not in athletic administration, but has contributed his time and talent to the high school athlete.

Dr Ellis has been a team physician and consultant for area high school, college, and professional teams for more than 30 years. He was instrumental in the implementation of free physical exams for Louisville's high school athletes.

Alliant Health System recently honored **Richard S. Wolf, MD**, with a "Wolf Roast and Hoedown." Dr Wolf, medical director of Kosair Children's Hospital and assistant dean of the University of Louisville School of Medicine since 1983, retired January 1, 1996.

Under Dr Wolf's leadership, Kosair Children's Hospital received regional and national recognition as a center of excellence for the medical care and treatment of children.

Dr Wolf supported and endorsed child advocacy and community outreach programs. One of those projects was Safety City, a tiny town where children receive instructions on boarding buses, crossing railroad tracks, using seatbelts, cycling safety, and crossing the street. Safety City is in its second year and has trained more than 4,500 children. Dr Wolf serves as "mayor" of the mini-metropolis.

Benjamin M. Rigor, MD, was one of the 1995 Twenty Outstanding Filipino-Americans in the United States and Canada selected by the *Filipino-American Image* magazine at their Sixth Annual Event in Washington, DC. Dr Rigor is professor and chairman of the Department of Anesthesiology, University of Louisville School of Medicine.

Dr Rigor founded three philanthropic organizations whose members perform surgery on indigent patients in the Philippines and other developing nations. He is also a regional and international speaker and lecturer.

UPDATES

Medicaid Managed Care Waiver

KMA President **Danny M. Clark, MD**, recently met with then **Lieutenant Governor-Elect Steve Henry, MD**, and others from the medical community to hear a presentation by CHR Secretary Masten Childers on the future of the Medicaid Managed Care Waiver approved by HCFA several weeks ago. This waiver, the brainchild of former Governor Jones and Masten Childers, would divide the state into eight managed care regions in which Medicaid services would be provided by a partnership of health care providers on a capitated fee basis.

Dr Henry was noncommittal about the plan, and KMA suggested a pilot project to test the feasibility of the concept prior to any widespread implementation.

KMA leadership and staff will continue to monitor the existing waiver and any other suggested changes to Kentucky's Medicaid program and will inform membership as information is received.

Red-haired Women May be More Susceptible to Endometriosis

University of Louisville researchers

report they have found a link between red hair and the occurrence of endometriosis, a condition which causes infertility in many women.

A preliminary study conducted at the U of L and the University of Mississippi schools of medicine has discovered redheads are twice as likely to suffer from endometriosis as women with other hair colors.

Specifically, the study revealed that of 148 patients seeking treatment for infertility, 83% of red-haired women had endometriosis compared with 42% of non-redheads.

Marvin A. Yussman, MD, **Joseph S. Sanfilippo, MD**, and **Christine L. Cook, MD**, all obstetrics/gynecology faculty members at U of L, conducted the local study of endometriosis.

The U of L study, said Dr Sanfilippo, was prompted by a comment from a member of the ob/gyn department who observed that physicians there were treating a lot of red-headed women for endometriosis. Researchers decided to conduct a more formal study which, they found, confirmed the observation.

"Nobody knows what causes this disease," Dr Sanfilippo explained. "Right now there are four good theories — and one of them is that the condition's roots are genetic. Red hair is inherited, and has been linked to defects of the immune system. Defects in the immune system have also been linked to women with endometriosis — there's a possible genetic connection."

AMA News for Your Benefit

- *Information-on-Request Service* is now being offered by AMA for four areas: coding products, managed care publications, statistics and data information, and the Physician's Recognition Award. The toll-free number is 1-800/621-8335; press 4 at the menu.
- *Capitation: The Physician's Guide* is

now available from the AMA. The 61-page book includes information on understanding the basic concepts of capitation, as well as practical advice about contracts, managing financial risk, evaluating capitation rates, and choosing a capitation consultant. Cost for the book is \$34.95 for AMA members, \$48.95 for nonmembers. To order, call 312/464-4726, order number #OP601595.

- Two new publications are available free of charge to medical students and residents. *Choosing a Specialty* is an annotated bibliography of general information useful to students in selecting a specialty. Call the AMA at 1-800/262-3211, ext 4753. Residents can get *Student Loan Manager*, a booklet containing facts on loan deferment and forbearance options, tips on managing paperwork, and resources on financial aid, by calling 1-800/262-3211, ext 5529.

KMA Membership Dues

You should have received your 1996 KMA membership dues statement which was payable by January 1, 1996. KMA and AMA dues remain unchanged for 1996.

A growing number of group practices are consolidating their physicians' dues statements into one statement (Superbill). Currently 26 groups, ranging in size from 3 to 114 members, participate in this program. If you have not received your 1996 dues statement or your practice is interested in the Superbill Program, please contact the KMA Membership Department.

Important Tax Information: For your records, please note that Association dues used for lobbying activities are not tax deductible. As a result, 14% of KMA dues and 25% of AMA dues for 1996 cannot be deducted as a business expense for federal income tax purposes.

Managed Care Workshop/Forum A Success

Over 150 Kentucky physicians attended KMA's recent managed care workshop/forum which was held in Lexington. Attendees heard presentations by nationally recognized speakers on the following topics:

- The managed care market — capitation, integrated delivery systems, and physician networks
- Selling your practice — practical tips and what physicians should know before selling
- Partnering with hospitals — physician response when approached by the hospital
- Contract negotiations — practical tips and physician rights

Due to the response, KMA's Physician Organization Study Committee hopes to host another timely workshop/forum focusing on managed care in the Spring of 1996.

Kentucky Physicians Care Program Begins 12th Year of Service

The KMA House of Delegates has again voted to continue the Kentucky Physicians Care program. The program, which begins its 12th year of providing service to non-Medicaid eligible indigent patients, has provided an estimated 220,000+ free physician services to 60,000 individuals since its inception.

All Kentucky physicians are invited and encouraged to participate in this nationally recognized and award-winning program. For additional information, contact Health Kentucky, 12700 Shelbyville Road, Louisville, KY 40243, phone 502/245-7896.

Rural Kentucky Medical Scholarship Fund, Inc Applications Now Available

Applications are now being accepted by the RKMSF for the 1996-97

academic year. The Fund has been in existence since 1945-46 and is designed to financially assist those medical school students who are willing to practice primary care medicine in designated rural areas of Kentucky upon graduation.

Applications are welcomed from residents of Kentucky who have been admitted to the U of L or U of K medical schools. The Fund will loan up to \$12,000 per year to those students selected to participate. For consideration, all applications must be received at the RKMSF office by **April 1.**

For an application or for more information about the RKMSF, please contact RKMSF staff at 502/426-6200.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Bell

Sankar Lakshman, MD — R
3121 Cumberland Ave, Middlesboro
40965
1973, Tirunelveli, India

Boyd

Mathew P. Samuel, MD — RHU
2109 Carter Ave, Ashland 41101
1974, Christian, India

Fleming

Hasib A. Ibne-Rasa, MD — IM
920 Elizaville Ave, PO Box 111,
Flemingsburg 41041
1989, King Edward, Pakistan

Hardin

Susan A. Gavin, MD — FP
906 Woodland Dr, Elizabethtown
42701

1986, Indiana
Chris J. Godfrey, MD — IM
820 Greenview Cir, Elizabethtown
42701

1992, U of Kentucky

Henderson

Clement F. Bernard, MD — C
319 8th St, Henderson 42420
1988, Hahnemann

Jefferson

James N. Hiken, MD — R
2940 Grinstead Dr, Louisville 40206
1989, U of Wisconsin

Eliot L. Thompson, MD — PD
3807 Stigwood Ct, Louisville 40218
1992, U of Louisville

Richard D. Clover, MD — FP
9327 Springbrooke Cir, Louisville
40241

1980, U of Oklahoma
Peter E. Tanguay, MD — P
1129 Cardinal Dr, Louisville 40213
1960, U of Ottawa, Canada

Knox

Robert A. Miller, MD — FP
PO Box 1150, Barbourville 40906
1991, U of Nebraska

Northern Kentucky

John A. Darpel, MD — OBG
20 Medical Village Dr Ste 302,
Covington 41017

1991, U of Kentucky
Norman I. Hirsch, DO — P
PO Box 19026, Cincinnati 45213-0026
1976, U of Health Sciences Coll of
Osteopathic

Pulaski

Magdy M. El-Kalliny, MD — NS
110 Hardin Ln Ste 1, Somerset 42501
1977, Ein Shams, Egypt

Jeffrey A. Ollo, MD — ORS
26 Oxford Way, Somerset 42501
1987, Indiana

Warren

William R. Harrigan, MD — FP
201 Park St, PO Box 90007, Bowling
Green 42101

1982, U of Toronto, Canada
Patricia J. Mercer, MD — A
201 Park St, Bowling Green 42101
1984, U of Louisville

Whitley

Terri L. Jagers, MD — GE
2 Trillium Way Ste 304, Corbin 40701
1987, U of Louisville

In-Training**Jefferson**

Mark Alan Ackermann, MD — OBG
Richard D. Carlisle, MD — EM
Randall K. Gibb, MD — OBG
Tina F. Simpson, MD — OBG

Lewis E. Wesley, MD
Liberty
1927-1995

Lewis E. Wesley, MD, a general practitioner, died October 19, 1995. Dr Wesley was a 1956 graduate of the University of Louisville School of Medicine and an active member of KMA.

Roy G. Wilson, MD
Campbellsville
1908-1995

Roy G. Wilson, MD, a retired family practitioner, died October 26, 1995. A 1943 graduate of the University of Louisville School of Medicine, Dr Wilson was a life member of KMA.

Owen S. Ogden, MD
Louisville
1910-1995

Owen S. Ogden, MD, a retired pediatrician, died October 29, 1995. Dr Ogden was a past president of the Louisville and Kentucky Pediatric Societies, a Fellow of the American Academy of Pediatrics, and a life member of KMA.

Phatick K. Mukherji, MD
Louisville
1924-1995

Phatick K. Mukherji, MD, a pediatrician, died December 8, 1995. A 1946 graduate of R. G. Kar Medical School, India, Dr Mukherji was an active member of KMA.

J. Campbell Cantrill, MD
Georgetown
1923-1995

J. Campbell Cantrill, MD, a retired family practitioner, died December 13, 1995. A 1950 graduate of the University of Virginia School of Medicine and a life member of KMA, Dr Cantrill's service to KMA included Chair of the Committee on State Legislative Activities, 9th District Trustee during 1970-73, Vice President, and as a member of the KMA Judicial Council for 18 years.

DEATHS

Antero J. Avenido, MD
Elizabethtown
1938-1995

Antero J. Avenido, MD, an anesthesiologist, died September 8, 1995. Dr Avenido graduated from Manila Central University in 1964 and was an active member of KMA.

Joe T. Pettey, MD
Russell Springs
1922-1995

Joe T. Pettey, MD, a general practitioner, died September 30, 1995. A 1951 graduate of the University of Louisville School of Medicine, Dr Pettey was an active member of KMA.

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| Financial Architects, Inc | 57 | Medical Protective Company | 62 |
| Humana Health Care Plans | 81 | National Coalition Against | |
| Impaired Physicians Program | 57 | Domestic Violence | 70 |
| KMA Practice Management Seminars | 57 | National Insurance Agency, Inc | 58 |
| KMA Public Education Committee | 57, 79 | PIE Mutual Insurance Company | 49 |

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JOURNAL OF THE
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Familial Cardiac Myxoma

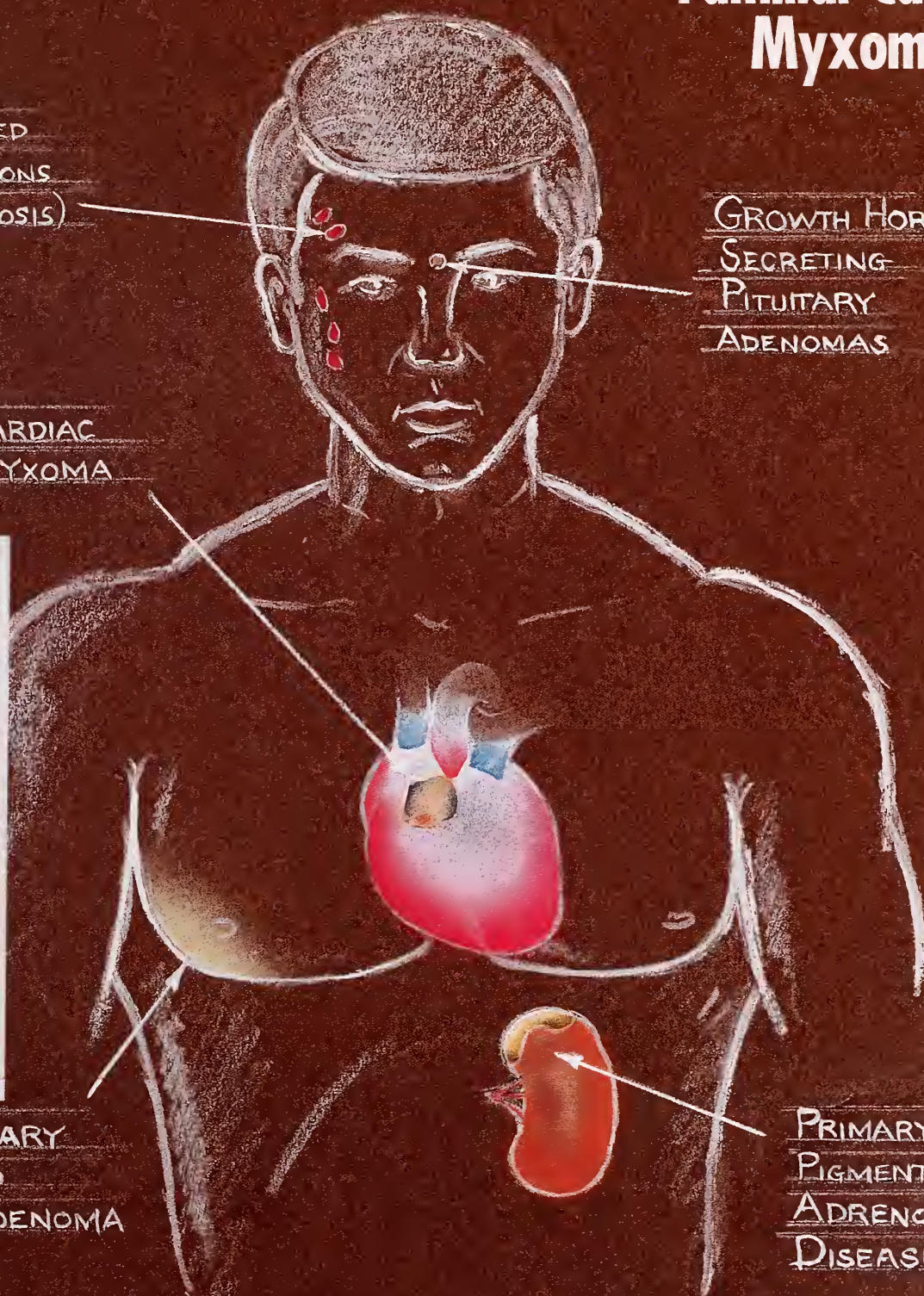
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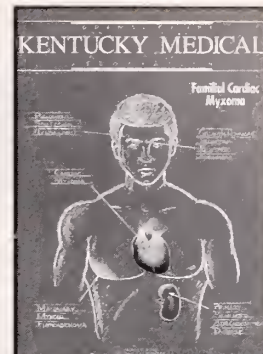


JOURNAL OF THE
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VOLUME 94, NUMBER 3

MARCH 1996

| | | |
|------------------------|------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------|
| COVER STORY | Familial Cardiac Myxoma — A Comprehensive Review of Reported Cases <i>Surjeet D. Singh, MD, FRCP; Allan M. Lansing, MD, PhD</i> | 96 |
| SCIENTIFIC | “Ovarian Asthma” — Fact or Fancy? <i>Martin Gotthardt, MD; J. D. Clark, MD; Thomas M. Roy, MD</i> | 105 |
| SPECIAL ARTICLE | Seat Belt Use in Kentucky — A Comparison of Five Measures <i>Robert H. McKnight, MPH, ScD; Sara K. Dawson, MA</i> | 110 |
| EDITORIAL | The Kungsholm <i>A. Evan Overstreet, MD, Editor</i> | 115 |
| ASSOCIATION | <i>Monitoring Medicine</i> New Board of Trustees Officer Profiles News | 93 118 120 |
| DEPARTMENTS | President's Page Advertisers' Guide Alliance Page Classifieds Continuing Education Information for Authors | 91 126 117 124 125 104 |



COVER: Cardiac myxoma with familial involvement is a rare manifestation of an uncommon tumor, which nevertheless has been reported with increasing frequency in the past two decades. Refer to page 96 for a comprehensive review of the international literature identifying reports of 25 families in which cardiac myxomas had occurred in more than one family member. Design and artwork by Lee Wade of Louisville.

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AMBITIONS, METHODS and WORK

While being consumed with the Kentucky Medical Association's legislative efforts to obtain a repeal of the provider tax, secure reasonable Medicaid reimbursement, and the invasion of managed care into my practice neighborhood, I received a friendly reminder from the KMA *Journal* staff that my contribution for the March *Journal* was due in early January.

Initially I had some difficulty in finding a relevant topic that would be current two months in the future. The legislative agenda will be won or lost by March. Medicaid reimbursements will have been addressed by the new political regime, or the Sixth Circuit Court will have issued its ruling. The freedom of my medical practice would have continued its inexorable downward spiral as the managed "cost" pendulum encroaches further into the west. These factors led me to consider more important facets of our profession.

No other profession faces the constant challenge of study and application of knowledge against the broad spectrum of disease. A foe which presents differently in each host or patient, creating an infinite number of variations of each problem; nor does any other profession experience the magnitude of grateful thanks from the people it serves.

Sir William Oster describes the "remarkable solidarity" caused by the scope of our profession.

"To wrest from nature the secrets

which have perplexed philosophers in all ages, to track to their sources the cause of disease, to correlate the vast stores of knowledge that they may be quickly available for the prevention and cure of disease — these are our AMBITIONS.

"To carefully observe the phenomena of life in all its phases, normal and perverted, to make perfect that most difficult of all arts, the art of observation, to call to aid the science of experimentation, to cultivate the reasoning faculty, so as to be able to know the true from the false — these are our METHODS.

"To prevent disease, to relieve suffering and to heal the sick — this is our WORK."

These words are as true today as they were in Oster's time — a century ago. As long as we keep in mind our true AMBITIONS, METHODS, and WORK, all else becomes minor details — mere inconveniences to be endured so that we may continue with the greatest profession in the world.

"... any member of which can take up his calling in any part of the world and find brethren whose language and methods and whose aims and ways are identical with his own."

The KMA should function as a gathering place for physicians of like mind where our AMBITIONS, METHODS, and WORK can be pursued, discussed, and compared in an atmosphere of unity and congeniality. Here the common



Harry W. Carloss, MD

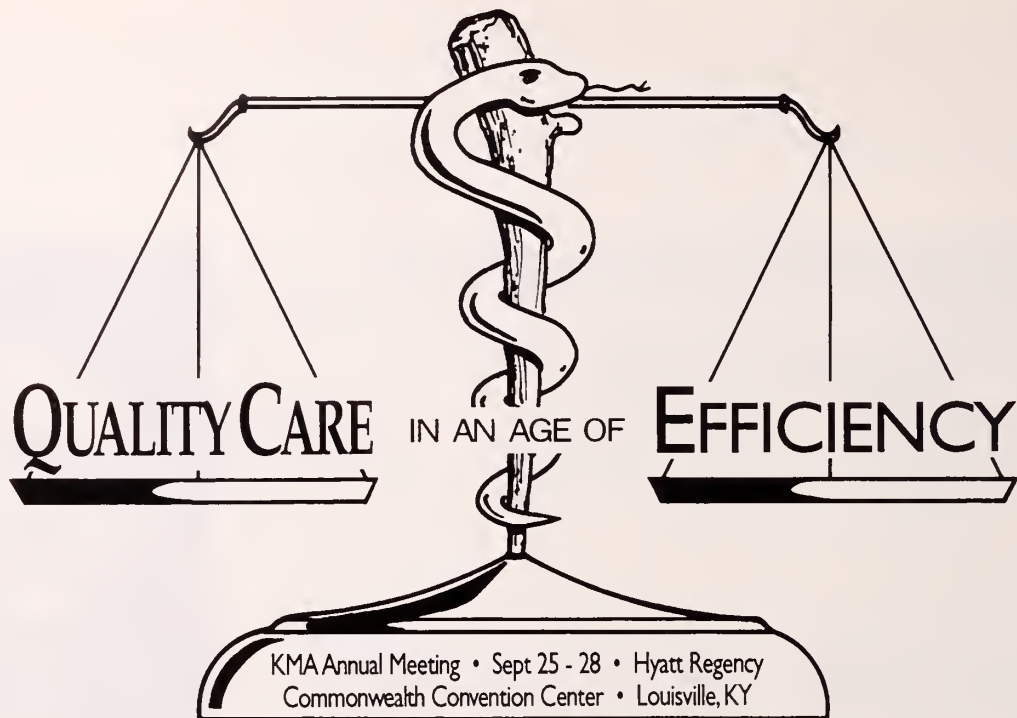
"As long as we keep in mind our true AMBITIONS, METHODS, and WORK, all else becomes minor details — mere inconveniences to be endured so that we may continue with the greatest profession in the world."

annoyances of everyday practice should not be allowed to divide us but should strengthen us together to pursue our AMBITIONS, METHODS, and WORK.

Harry W. Carloss, MD
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References

Oster, Sir William. *Aequanimitas With Other Addresses*. 3rd ed. Philadelphia, PA: The Blakiston Co; Feb 1932.



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1996 KMA Legislative Seminar Attracts SRO Crowd

A standing-room-only crowd of more than 200 physicians, spouses, and staff attended KMA's Legislative Seminar in Frankfort on January 17. Those in attendance heard the latest on the status of HB250, Medicare and Medicaid, Workers' Compensation, and other issues of major significance facing the medical community in the Commonwealth of Kentucky.

Featured speakers were Lt Governor Stephen L. Henry, MD; House Speaker Jody Richards; CHR Secretary John Morse; Workers' Compensation Commissioner Walt Turner; Chair of the Health Policy Board Jack Hall; and KMA officers and staff. Senator James D. Crase, MD, and Representatives Bob M. DeWeese, MD, and Ernest L. Fletcher, MD, also addressed the group and fielded numerous questions of interest to the assembly.

KMA officers addressing the group included

President Danny M. Clark, MD; President-Elect William H. Mitchell, MD; Board Chair Harry W. Carlloss, MD; and Secretary-Treasurer and KEM-PAC Chair William P. VonderHaar, MD.

After the seminar, many of the attendees went to the Capitol and met with their Legislators to discuss issues of concern to Kentucky physicians. It cannot be overemphasized — **YOUR PARTICIPATION AND INVOLVEMENT IN THE LEGISLATIVE PROCESS ARE ESSENTIAL.** While KMA leadership and staff routinely meet with Legislators to represent your interest, **NOTHING IS MORE EFFECTIVE THAN COMMUNICATION FROM A CONSTITUENT — YOU!!**

GET INVOLVED — YOU CAN MAKE A DIFFERENCE!

Please turn the page for a pictorial overview of the 1996 Seminar.

KMA



MONITORING MEDICINE



LtoR — KMAA Past Presidents Gerry Montgomery, Carol Goodin, and Joyce Clark (all wives of KMA Presidents) are pictured with Jefferson County Alliance President Mary Falk.



Joel O. Lillevig, MD, Paducah, and KMA Past President and Senior AMA Delegate Donald C. Barton, MD, shared a humorous moment with Jody Richards, Kentucky's Speaker of the House.



Lt Governor Steve Henry, MD, and KMA President Danny M. Clark, MD, exchanged a handshake at the end of the Lt Governor's remarks.



KMA's Legislative Chair Wally O. Montgomery, MD, is pictured in the nave of the Capitol.

Facing page, top LtoR — State Representatives Bob M. DeWeese, MD, and Ernest L. Fletcher, MD, are pictured with KMA President Clark, KMA Director of Public Affairs Don R. Chasteen, and KMA Legislative Consultant William Doll; KMA President-Elect William H. Mitchell, MD, and Board Chair Harry W. Carloss, MD, addressed the group.

Center, LtoR — Jan Crase, KMAA Vice President of Legislation and wife of Senator James D. Crase, MD, spoke on behalf of the Alliance; John Morse, Deputy Secretary CHR, shared in fielding questions with Lt Governor Henry; KEMPAC Chair and KMA Secretary-Treasurer William P. VonderHaar, MD, spoke to the group.

Bottom, LtoR — Senator James D. Crase, MD, and Representatives DeWeese and Fletcher answered questions from the audience; Walter W. Turner, Workers' Compensation Commissioner, and Jack Hall, Chair of the Health Policy Board, presented timely information for the seminar.

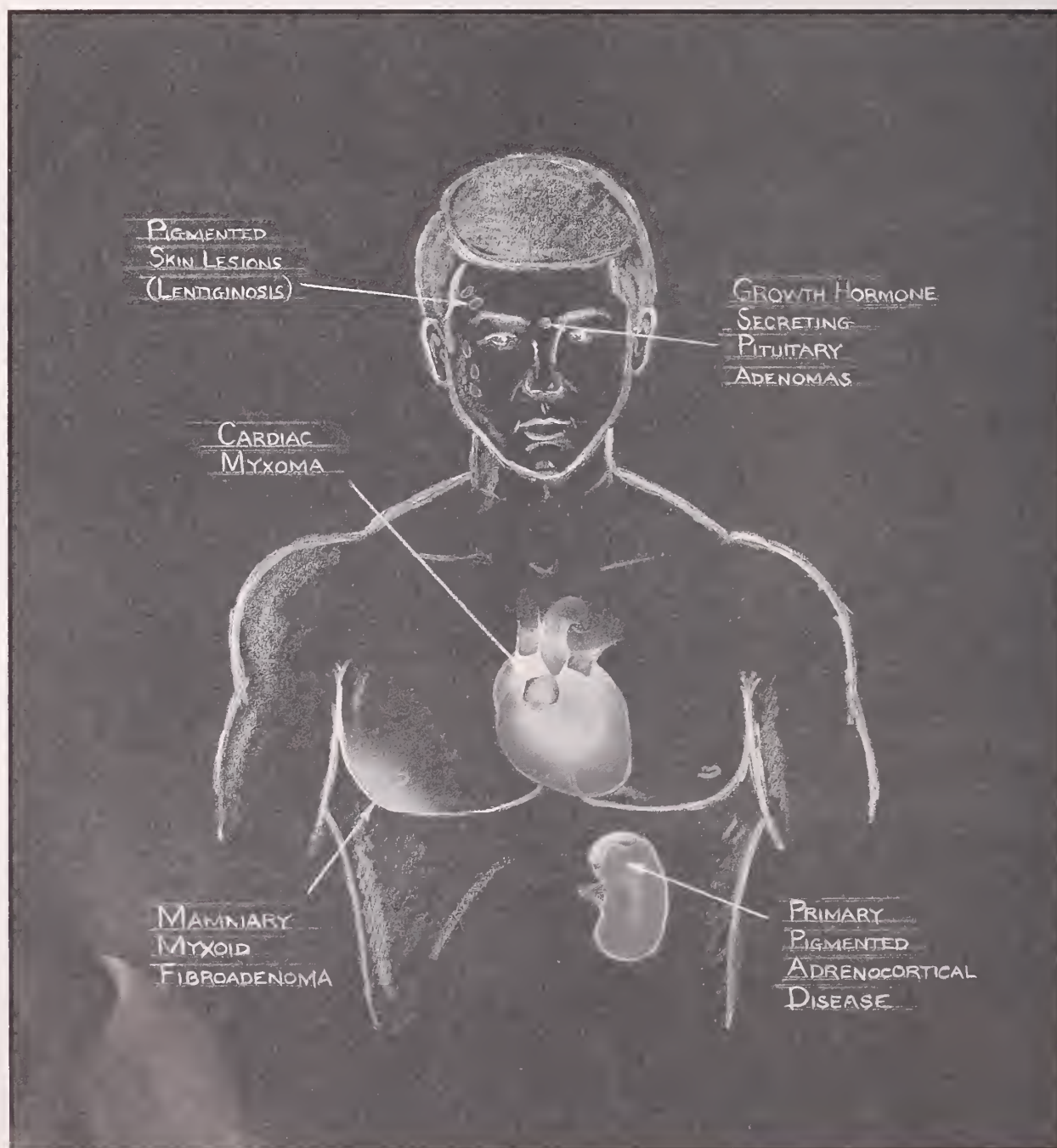
MONITORING MEDICINE



Familial Cardiac Myxoma

A Comprehensive Review of Reported Cases

Surjeet D. Singh, MD, FRCP; Allan M. Lansing, MD, PhD



Background: Cardiac myxoma with familial involvement is a rare manifestation of an uncommon tumor, which nevertheless has been reported with increasing frequency in the past two decades. As a feature of the hereditary Carney syndrome, cardiac myxoma occurs at a much younger age, often has multicentric origins, and tends to recur. We report the case of a family in which three members had cardiac myxoma and two had other characteristics of the Carney syndrome.

Methods: We have made a comprehensive review of the international literature from 1971-1992 to determine the incidence and clinical presentation of cardiac myxoma when diagnosed in more than one family member or first-degree relative.

Results: Twenty-six cases of familial cardiac myxoma, involving 68 family members, have now been reported in the United States, Europe, and Australia. One-fourth of these reports have appeared in the past 4 years alone. The rate of diagnosis at autopsy has declined from 40% in early reports to a current 17%. Seventeen episodes of recurrence (25%) at the same or different intracardiac sites have been documented, approximately twice the rate of recurrence in isolated cases.

Conclusions: The diagnostician should be alert for evidence of cutaneous, endocrine, or testicular features of the hereditary Carney syndrome in young patients who have cardiac myxoma. In the families of these patients, all first-degree relatives should be examined regularly for evidence of cardiac myxoma.

Cardiac myxoma is rare, yet it is the most common tumor of the heart, accounting for 40% to 50% of all heart tumors.^{1,2} Myxomas may appear at any age but occur most frequently after midlife. Slightly more prevalent in women, myxomas are usually found as single sporadic lesions and are seldom malignant.

Familial myxoma has been reported with increasing frequency as the means of diagnosis has advanced. A "syndrome" subset of this group of cardiac myxomas is associated with (1) cutaneous myxomas, (2) pigmented skin lesions, (3) endocrine dysfunction, (4) large-cell calcifying Sertoli cell tumors of the testes, (5) mammary myxoid fibroadenomas, (6) growth hormone secreting pituitary adenomas, and (7) psammomatous melanotic schwannomas (Fig 1).^{3,4} Myxomatous lesions in these patients occur at much younger age and have common clinical and

pathological features with regard to age of onset, multicentric origin in other chambers of the heart, and the tendency to recur. These neoplasms have a higher incidence in males and are less common in the left atrium.⁵ Recurrent myxomas may be present at multiple sites.

A review of the international literature identified reports of 25 families in which cardiac myxoma had occurred in more than one family member (Table 1).^{6,29} We describe here the cases of one other family, in whom a mother and two sons had cardiac myxoma and two other sons had syndrome-associated myxomatous tumors.

Case Reports

Patient #1: A 32-year-old female had symptoms of easy fatigability, loss of weight, and pedal edema in 1971. Cardiac catheterization showed a right atrial myxoma which was resected. Eight years later, the patient had pulmonary embolism and myxomatous lesions were removed from beneath both great toenails. A left atrial myxoma was identified by echocardiography and excised.

From the Humana Heart
Institute International,
Louisville, Kentucky

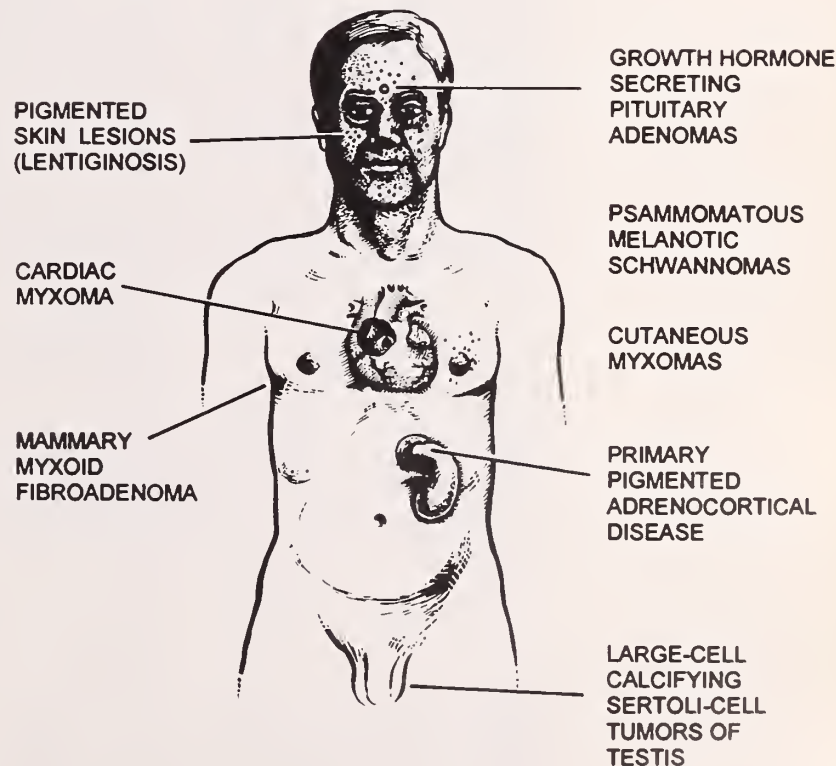


Fig 1 — Features of syndrome myxoma (Carney's syndrome).

Familial Cardiac Myxoma

Table 1. Familial Cardiac Myxoma—Review of reported cases

| Reporting author | Family members | Age | Location of tumor | Method of diagnosis |
|------------------------------------------------------------|-----------------------|----------------|---------------------------------------------------------|---------------------|
| Krause, 1971 ⁶ | Brother | 25 | LA | Autopsy |
| | Brother | 37 | RVOT | Coth |
| Heydarn, 1973 ⁷ and Kleid, 1973 ⁸ | Brother | 14 | LA, R fem artery | Cath, echo |
| | Brother | 16 | RA | Cath, echo |
| Farah, 1975 ⁹ | Brother | 21 | RA | Cath |
| | Sister | 30 | LA | Cath, echo |
| Liebler, 1976 ¹⁰ | Brother, A | 25 | LA | Autopsy |
| | Brother, B | 37 | RV | NR |
| | Brother, B | 42, new site | LA | Coth; autopsy |
| | Brother, C | 34 | RA(2), RV, LA | Cath, echa |
| | Brother, D | 46 | RV, LA | Cath, echa |
| Siltanen, 1976 ¹¹ | Mather | 33 | RA, LA | Cath |
| | San | 12 | LA | Cath |
| | San | 19 | RA | Cath, echo |
| | San | 18 | LA | Cath, echo |
| ŠMorgan, 1977 ¹² | Sister | 24 | LA, LV | Echo, coth |
| | Brother ⁴³ | NR | "Cordiac myxoma" | NR |
| Crawford, 1978 ¹³ | Mather | NR | LA | Autopsy |
| | Daughter | 12 | RA | Cath |
| Labaux, 1978 ¹⁴ | Male twin | 23 | RV | Cath, echo |
| | Male twin | 23 | RV | Cath, echa |
| Powers, 1979 ¹⁵ | Father | 48 | RA(2) | Cath, echa |
| | Daughter | 19 | RVOT | Cath, echa |
| Prappe, 1980 ¹⁶ | Brother | 16 | LV, testis | Autopsy |
| | Brother | 10 | LA, testis | Autopsy |
| Tway, 1981 ¹⁷ | Sister | 25 | RA, LA | Echo |
| | Sister | 13 | LA | NR |
| Schweizer-Cogionut, 1982 ¹⁸ | Brother | 4 | LA | Autopsy |
| | Sister | 36 | LA | Autopsy |
| ŠBorlow, 1983 ¹⁹ | Sister | 26 | RA(4); myxoid tumor of uterus; adrenal hyperplasia | Echa |
| | Sister ⁴³ | 28 | Site NR; adrenal hyperplasia | NR |
| Grouer, 1983 ²⁰ | Father | 56 | LA | Echo |
| | Daughter | 16 | LA | Cath |
| | | 18, recurrence | LA | Cath |
| | | 20, recurrence | RA, LA | Cath |
| | | 29, recurrence | RA | Cath |
| Ortonne, 1984 ^{3, 39} | Mother | NR | NR | NR |
| | San | NR | NR | NR |
| Gray, 1985 ²¹ | Sister | NR | LA | Autopsy |
| | Sister | 18 | LA | Cath |
| | | 29, recurrence | LA, RA | Cath |
| | | 42, recurrence | RV, TV, LA | Cath, echa |
| Richter, 1985 ²² | Mather | 49 | LA | Echa |
| | Daughter | NR, recurrence | LA | Echo |
| | | 17 | LA | Echo |
| Wilsher, 1986 ²³ | Mother | 21 | RA | Angiography |
| | Daughter | 29, new site | LA | Cath |
| | | 14 | LVOT; vaginal myxoid neurofibroma; mammary fibroadenoma | Cath |
| Schuiki, 1987 ²⁴ | Mather | 64 | LA | Autopsy |
| | San | 33 | LA | Echa |

| | | | | |
|-------------------------------------|------------|----------------|-----------------------------------------------------------------|------------|
| Pagola-Caltasca, 1989 ²⁵ | Mather San | 42 | LA | Cath, echa |
| | | 14 | RV | Coth, echa |
| Haught, 1991 ²⁶ | Mather | 26 | RA | NR |
| | | 27 | myxoid leiomyoma, uterus | — |
| | | 29, recurrence | RA | Echo |
| | | 32, new site | LA | Echa |
| | | 34, recurrence | LA | Echa |
| | Daughter | 7 | LA | NR |
| | Sister | 30 | LA | Echo |
| | Uncle | 46 | LA | NR |
| Lazarra, 1991 ²⁷ | Brother | 46 | Multiple | Echo |
| | Brather | 54 | Multiple | Echo |
| | Sibling | >30 | NR | NR |
| | Sibling | >30 | NR | NR |
| | Sibling | >30 | NR | NR |
| Chaudran, 1992 ²⁸ | Mother | 42 | LA | Echa, cath |
| | Doughter | 15 | LA | Echa |
| | Doughter | 12 | LA | Echo |
| van Gelder, 1992 ²⁹ | Mother | 26 | RA | Echo |
| | | 29, recurrence | RA | Echa |
| | | 32, new site | LA | Echa |
| | | 34, recurrence | LA, adrenacartilcol hyperplasia | Echa |
| | Doughter | 8 | LA | Autopsy |
| | Sister | 31 | RA | Echo |
| | Uncle | 46 | LA, esophageol psammomatous schwannama; adrenacartilcol disease | Autopsy |
| | | | | |
| von Gelder, 1992 ²⁹ | Mother | 56 | LV | Coth |
| | Doughter | 38 | RA, LA(>1) | Echa |
| | Grondsan | 16 | LA(4), RA(1) | Cath, echa |
| Present report | Mother | 32 | RA | Cath |
| | | 40, new site | LA, cutaneous myxamas | Echa |
| | | 46, recurrence | LA | Echa |
| | Son | 21 | LV, multiple | Echa |
| | | 24, new site | RA | Echa |
| | Son | 30 | RA | Echo |
| | Son | 21 | Large-cell colcifying Sertali cell tumor of testis | — |
| | Son | 21 | Myxamataus lesion, breast | — |

LA = left atrium

LV = left ventricle

RVOT = right ventricular outflow tract

LVOT = left ventricular outflow tract

NR = not reported

RA = right atrium

RV = right ventricle

Cath = cordioc catheterization

Echa = echocardiography

§ Subsequent diagnosis of cordioc myxama in a sibling was reported by a research group that did not include the ariginal investigator.

At age 46, upon routine echocardiography and subsequent cardiac catheterization, the patient was found to have a recurrent left atrial myxoma near the right pulmonary vein. She had been asymptomatic except for one episode of supra-

ventricular tachycardia and dietary-induced weight loss. Her medical history was significant for excision of two mammary lesions, one of which was fibroadenoma, and a hemorrhoidectomy. Physical examination was within normal

Familial Cardiac Myxoma

limits. Upon auscultation, S_1 was diminished in intensity. S_2 was moderately widely split and varying in intensity. S_3 and S_4 were not heard.

At the time of surgery, a large, friable, gelatinous tumor was found to be located at the junction of the right pulmonary vein and the atrial septum and appeared to arise from the previous suture line. The tumor was excised along with a portion of the pulmonary vein and adjacent atrial septum. All other cardiac chambers were explored but no other masses were seen.

Because the myxomas had been established as a familial occurrence with involvement of two of the patient's sons, adrenal function was assessed preoperatively. Cortisol secretion was found to be at a normal level. For the same reason, two blue nevi were excised from the chest and abdomen at the time of the operative procedure and showed no abnormal pathology.

Postoperative recovery was uneventful. A follow-up echocardiogram was performed 8 years later and showed no further tumor.

Patient #2: The son of patient #1 presented at age 21 with an acute onset of headache, nausea, and vomiting, right arm paresthesia, and inappropriate speech. Computerized tomography and magnetic resonance imaging of the head were negative. Electroencephalography was questionable for left hemispheric ischemia. Symptoms cleared within 3 days without residual deficit.

At the time of this admission, physical examination was within normal limits and auscultation revealed normal S_1 and S_2 with no S_3 or S_4 . There was a grade I/VI systolic murmur at the apex. Echocardiography showed a mass attached to the mid-inferolateral wall of the left ventricle.

An apical left ventriculotomy was performed with excision of a 1.5 cm multiloculated hemorrhagic tumor arising from the free wall, involving the base of one of the papillary muscles. Several other small tumors on the free wall were removed separately, as was another tumorous mass on the septum just distal to the mitral valve. The mitral valve itself appeared normal. Exploration of the left atrium revealed no tumors.

Three years later, at age 24, the patient again gave a history of periodic numbness in his left hand of 3 months' duration, similar to symptoms preceding his previous stroke. Upon examination, the S_1 was increased in intensity, moderately split, and best heard at the left lower sternal border. S_2 was normal in intensity, physiologically split, and best heard at the left lower sternal border. No S_3

or S_4 , opening snaps, or tumor plops were heard. There was a soft diastolic rumble at the left lower sternal border with presystolic accentuation. An echocardiogram revealed a mass attached to the right atrial septum (Fig 2A).

At surgery a huge gelatinous tumor was found filling the right atrium and intermittently occluding flow through the tricuspid valve (Fig 2B). This was excised along with its adjacent atrial septum. The incision in the septum was enlarged to explore the left atrium and left ventricle. No recurrent tumor was found on the left side. Additionally, the right ventricle and tricuspid valve were explored and found to be free of tumor. The defect in the atrial septum was closed with a patch graft. The patient made an uneventful recovery and was discharged on the fifth postoperative day.

Patient #3: The son of Patient #1 and brother of Patient #2, presented at age 30 with a 1-year history of spontaneous numbness of the left hand fingers and severe alternating bilateral headache of short duration. The patient related no associated history of syncope, presyncope, dizziness, speech deficit, or other motor problems. Medical history included hernia repair in childhood and a fractured femur stabilized with a metal plate.

Auscultation revealed an S_1 of normal intensity and best heard at the left lower sternal border. S_2 was physiologically split and best heard at the left sternal border. S_3 and S_4 were not heard. No murmurs, opening snaps, or tumor plops were heard.

Because of familial history of myxoma, echocardiography was performed and showed a right atrial myxoma. Intraoperatively, a gelatinous, hemorrhagic, multiloculated tumor was found to fill most of the right atrium and extend through the septum into the left atrium. The myxoma was excised along with the atrial septum, which was repaired with a patch graft. Exploration of both ventricles revealed no additional tumor. The patient recovered without significant complications and was discharged on the fifth postoperative day.

Patient #4: A sibling of Patients #2 and #3 had a right testicular tumor removed at age 21. Morphology was that of a large-cell Sertoli calcifying tumor. At that time the echocardiogram was normal, as was a recent repeat examination.

Patient #5: Another sibling of Patients #2 and #3 had a pea-sized myxoma removed from the breast at age 21. A recent echocardiogram showed no intracardiac lesions.



Fig 2A — Right atrial myxoma shown by echocardiography.

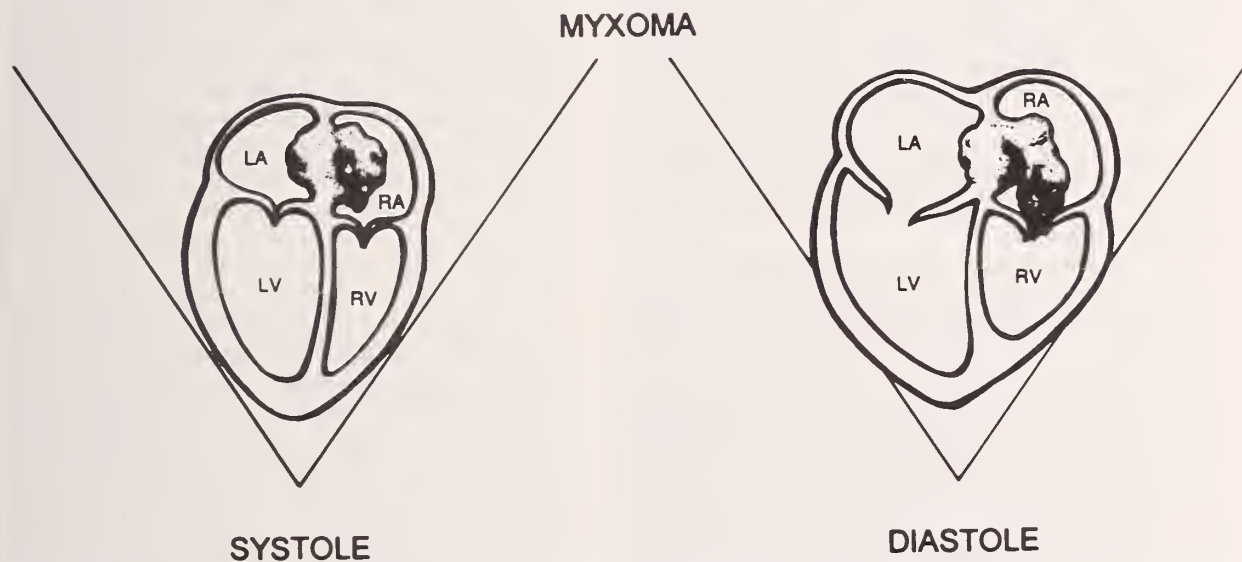


Fig 2B — Right atrial myxoma protruding into tricuspid value. Interference with right atrial blood flow produces diastolic rumble.

Three additional siblings of Patients #2, 3, 4, and 5 as well as two pre-adolescent children of Patient #4 have been examined by echocardiography, but as of date no intracardiac masses have been identified in any other family member.

Discussion

With Crafoord's first successful excision of an atrial myxoma in 1954,³⁰ surgical removal of the tumor came to be considered a curative treatment for what had frequently been identified at

Familial Cardiac Myxoma

autopsy. The malignant potential of myxoma became a concern after tumor recurrence was reported in 1967.³⁰ Diagnosis of cardiac myxoma has subsequently been facilitated by advances in echocardiography that permit earlier, more accurate recognition of intracardiac masses. Surgical resection is now associated with less than 5% mortality.³¹

In 1971, the first case of familial involvement was reported by Krause and colleagues.⁶ Within a decade, a total of 10 families were reported to have hereditary occurrences of cardiac myxoma, 40% of whom had at least one family member diagnosed post-mortem. Of the families reported from 1981-1989, this finding at autopsy had decreased to 33%, and in those reported from 1990-1993, had further dropped to 17%. Our comprehensive review of the 26 known cases of familial cardiac myxoma showed that 23% have been reported in the past 4 years alone.

Carney's recognition of a hereditary syndrome involving multiple discrete physiological systems resolved other attempts to correlate these clinical presentations.^{3,4} The early mnemonic acronyms of NAME (nevi, atrial myxoma, myxoid neurofibroma, and ephelides)³² and LAMB (lentigines, atrial myxoma, mucocutaneous myxomas, and blue nevi)³³ have been supplanted by identification of eight characteristic features, of which cardiac myxoma is the most serious. Carney's syndrome has now been reported in more than 40 families.²⁹

Benign tumors of the heart include myxoma (30.5%); lipoma (10.5%); papillary fibroelastoma (9.9%); rhabdomyoma (8.5%); and rarely, fibroma, hemangioma, teratoma, mesothelioma, glandular cell tumor, neurofibroma, and lymphangioma.³⁴ Malignant primary cardiac tumors are predominantly sarcomas and include angiosarcoma (9.2%), rhabdomyosarcoma (6.1%), fibrosarcoma (3.3%) and various rare morphologies.³⁴

Myxomas have no distinctive signs and symptoms that aid the clinician, and thus only 5% to 10% of all cases are diagnosed clinically.³⁵ By auscultation, a myxoma can be identified by either an "opening snap" resulting from tension on the tumor stalk or the "plop" of the tumor falling back onto the atrial wall during diastole.^{36,37} In Patient #2 in our series, delayed filling of the right ventricle due to the myxoma may have been responsible for the wide splitting of S₁ at the left lower sternal border, which may have also caused the diastolic rumble. Splitting of S₁ was normal postoperatively, and the diastolic

rumble disappeared. Three-fourths of cardiac myxoma patients have a mitral diastolic murmur, half have a mitral systolic murmur, and a third have an additional sound heard after the second heart sound.³⁸ A majority of patients show evidence of pulmonary hypertension due to pulmonary venous occlusion.³⁸ This was a potential complication in Patient #1, whose third cardiac myxoma, a recurrence in the left atrium, had begun to invade the right pulmonary vein.

Because of their tissue friability, right-sided myxomas can produce pulmonary embolism or paradoxical systemic emboli. Emboli from left-sided myxomas may likewise spread systemically. Patient #1 had both pulmonary and peripheral embolism (myxomatous lesions on both great toes) and Patient #2 had preoperative numbness in his right arm. A possible etiology in his case was the presence of cerebral microemboli from the left ventricular myxoma. Similar numbness in the left hand during the second preoperative period could have resulted from a paradoxical embolus through the patent foramen ovale.

Constitutional symptoms occur in 90% of all patients with cardiac myxoma and are produced by the body's immune response to the tumor, by degeneration of the tumor mass, or by multiple systemic emboli.^{31,36} Patients are likely to present with fever, weight loss, arthralgia, fatigue, elevated erythrocyte sedimentation rate, anemia, leukocytosis, thrombocytopenia, or hypergammaglobulinemia. Raynaud's phenomenon and finger clubbing may also be seen.

Families in which syndrome myxoma has been reported have shown variability in the number of characteristic features manifested by the affected family members.³⁹ In the family we report here, four of the eight syndrome components have been diagnosed. Large-cell calcifying Sertoli cell tumors of the testis are reported in 46% of patients with syndrome myxoma, but it is not known how many of these patients have cardiac tumors as well.^{40,41} The son of our index case who had a testicular tumor has, at age 26, not shown cardiac involvement. Another son of our index patient had a myxoid fibroadenoma of the breast removed at age 21 and likewise has not shown cardiac involvement, although 52% of patients with mammary myxomatous lesions also have cardiac myxomas.⁴²

The pattern of hereditary transmission in familial cardiac myxoma appears to be that of autosomal dominance involving parent-child as well as sibling-sibling.^{23,29,39} Wilsher has specu-

lated that the pathogenesis of cardiac myxoma may be linked with a neural crest anomaly.²³ Another hypothesis has implicated the Coxsackie B4 virus, which has been found in myxomal cytoplasm.²⁹

The incidence of recurrent cardiac myxoma is 5% to 14% in isolated cases.³⁶ Among the 68 family members in our comprehensive review, however, 17 episodes of recurrence at the same or different sites have been documented, raising the incidence in familial cases to 25%. It is not clear whether this results from the standard etiology of recurrence (multiplicity of sites, incomplete excision, or failure to detect small or fragmented tumors intraoperatively) or from poorly understood reasons.

In the family we present here, two patients had recurrent myxoma and one had synchronous myxoma. In Patient #1, the recurrent left atrial tumor was resected from along the previous suture line. Patient #2 had multicentric lesions in the left ventricle with contralateral recurrence in the right atrium. Most clinicians advocate extensive resection of the tumor and adjacent myocardium, especially the atrial septum, where "pre-tumor" cells are presumed to be concentrated near the foramen ovale.^{2,36} Because of the tendency of familial myxomas to recur, it is important to completely excise the primary site of attachment and thoroughly search all chambers of the heart.

Conclusion

Although the incidence of familial cardiac myxoma is extremely low despite being more frequently reported, the diagnostician should be alert for evidence of pigmented skin lesions, endocrine dysfunction, or testicular masses in young patients who have cardiac myxoma. If any of the eight features of Carney's syndrome are identified in more than one family member, all first-degree relatives should be examined periodically for evidence of cardiac myxoma.

References

1. Larsson S, Lepore V, Kennergren C. Atrial myxomas; result of 25 years' experience and review of the literature. *Surgery*. 1989;105:695-698.
2. Attum AA, Johnson GS, Masri Z, Girardet R, Lansing AM. Malignant clinical behavior of cardiac myxomas and "myxoid imitators." *Ann Thorac Surg*. 1987;44:217-222.
3. Carney JA, Gordon H, Carpenter PC, Shenoy BV, Go VLW. The complex of myxomas, spotty pigmentation, and endocrine overactivity. *Medicine*. (Baltimore) 1985;64:270-283.
4. Carney JA. Psammomatous melanotic schwannoma; a distinctive heritable tumor with special associations, including cardiac myxoma and the Cushing syndrome. *Am J Surg Pathol*. 1990;14:206-209.
5. Carney JA. Differences between nonfamilial and familial cardiac myxoma. *Am J Surg Pathol*. 1985;9:53-55.
6. Krause S, Adler LN, Reddy PS, Magovern GJ. Intracardiac myxoma in siblings. *Chest*. 1971;60:404-406.
7. Heydorn WH, Gomez AC, Kleid JJ, Haas JM. Atrial myxoma in siblings. *J Thorac Cardiovasc Surg*. 1973;65:484-486.
8. Kleid JJ, Klugman J, Haas J, Battcock D. Familial atrial myxoma. *Am J Cardiol*. 1973;32:361-364.
9. Farah MG. Familial atrial myxoma. *Ann Intern Med*. 1975;83:358-360.
10. Liebler GA, Magovern GJ, Park SB, Cushing WJ, Begg FR, Joyner CR. Familial myxomas in four siblings. *J Thorac Cardiovasc Surg*. 1976;71:605-608.
11. Siltanen P, Tuuteri L, Norio R, Tala P, Ahrenberg P, Halonen PI. Atrial myxoma in a family. *Am J Cardiol*. 1976;38:252-256.
12. Morgan DL, Palazola J, Reed W, et al. Left heart myxomas. *Am J Cardiol*. 1977;40:611-614.
13. Crawford FA Jr, Selby JH Jr, Watson D, Joransen J. Unusual aspects of atrial myxoma. *Ann Surg*. 1978;188:240-244.
14. Laboux L, Mussini-Montpellier J, Michaud JL, et al. Myxome du ventricule droit chez des jumeaux monozygotes; ablation chirurgicale. *Arch Mal Coeur*. 1978;71:953-959.
15. Powers JC, Falkoff M, Heinle RA, Nanda NC, et al. Familial cardiac myxoma; emphasis on unusual clinical manifestations. *J Thorac Cardiovasc Surg*. 1979;77:782-788.
16. Proppe KH, Scully RE. Large-cell calcifying Sertoli cell tumor of the testis. *Am J Clin Pathol*. 1980;74:607-619.
17. Tway KP, Shah AA, Rahimtoola SH. Multiple biatrial myxomas demonstrated by two-dimensional echocardiography. *Am J Med*. 1981;71:896-899.
18. Schweizer-Cagianut M, Salomon F, Hedinger CE. Primary adrenocortical nodular dysplasia with Cushing's syndrome and cardiac myxomas. *Virchows Arch [Pathol Anat]*. 1982;397:183-192.
19. Barlow JF, Abu-Gazaleh S, Tam GE, et al. Myxoid tumor of the uterus and right atrial myxomas. *SD J Med*. 1983;36:9-13.
20. Grauer K, Grauer MC. Familial atrial myxoma with bilateral recurrence. *Heart Lung*. 1983;12:600-602.
21. Gray IR, Williams WG. Recurring cardiac myxoma. *Br Heart J*. 1985;53:645-649.
22. Richter G, Zegelman M, Wagner R, et al. Familiäre haufung von kardialen myxomen. *Z Kardiol*. 1985;74:60-63.
23. Wilsher ML, Roche AHG, Neutze JM, Synek BJL, Holdaway IM, Nicholson GI. A familial syndrome of cardiac myxomas, myxoid neurofibromata, cutaneous pigmented lesions, and endocrine abnormalities. *Aust NZ J Med*. 1986;16:393-396.
24. Schuiki E, Hedinger C. Kombination von herzmixom mit primär nodulärer dysplasie der nebennierenrinde. *Schweiz Med Wochenschr*. 1987;117:595-603.
25. Pagola-Caltasco JA, Galante-Chicerul J, Alvarado RR, et al. Mixoma familiar; informe de un caso y revision de la literatura. *Arch Inst Cardiol Mex*. 1989;59:169-173.
26. Haught WH, Alexander JA, Conti CR. Familial recurring cardiac myxoma. *Clin Cardiol*. 1991;14:692-695.
27. Lazarra RR, Park SB, Magovern GJ. Cardiac myxomas; results of surgical treatment. *J Cardiovasc Surg*. 1991;32:824-827.
28. Chaudron JM, Jacques JM, Heller FR, Cheron P, Luwaert R. The myxoma syndrome; an unusual entity. *Eur Heart J*. 1992;13:569-573.
29. van Gelder HM, O'Brien DJ, Staples ED, Alexander JA.

Familial Cardiac Myxoma

- Familial cardiac myxoma. *Ann Thorac Surg.* 1992;53:419-424.
30. Crafoord C. Discussion on late results of mitral commissurotomy. In Lam CR, ed. *Proceedings of the International Symposium on Cardiovascular Surgery*. Philadelphia: WB Saunders, pp 202-211, 1955.
30. Gerbode F, Kerth WJ, Hill JD. Surgical management of tumors of the heart. *Surgery.* 1967;61:94-101.
31. Salcedo EE, Cohen GI, White RD, Davison MB. Cardiac tumors; diagnosis and management. *Curr Prob Cardiol.* 1992;17:79-137.
32. Atherton DJ, Pitcher DW, Wells RS, et al. A syndrome of various cutaneous pigmented lesions, myxoid neurofibromata, and atrial myxoma; the NAME syndrome. *Br J Dermatol.* 1980;103:431-429.
33. Rhodes AR, Silverman RA, Harist TJ, et al. Mucocutaneous lentigines, cardiomucocutaneous myxomas, and multiple blue nevi; the LAMB syndrome. *J Am Acad Dermatol.* 1984;10:72-82.
34. McAllister HA, Fenoglio JJ Jr. Tumors of the cardiovascular system. In *Atlas of Tumor Pathology*. 2nd series. Fascicle 15. Washington, DC: Armed Forces Institute of Pathology, 1978.
35. Bloor CM, O'Rourke RA. Cardiac tumors: clinical presentation and pathologic correlations. In *Curr Prob Cardiol*. Chicago: Yearbook Medical Publishers, 1984.
36. Markel ML, Waller BF, Armstrong WF. Cardiac myxoma; a review. *Medicine.* 1987;66:114-125.
37. van Son JAM, Cortn PMJ, Poels EFJ, van de Wal JCM, Lacquet LK. Cardiac myxoma; the grand masquerader. *Nether J Surg.* 1991;43:75-78.
38. Fisher J. Cardiac myxoma. *Cardiovasc Rev Rep.* 1983;4:1195-1199.
39. Carney JA, Hruska LS, Beauchamp GD, Gordon H. Dominant inheritance of the complex of myxomas, spotty pigmentation, and endocrine overactivity. *Mayo Clin Proc.* 1986; 61:165-172.
40. Wallace TM, Levin HS, Ratliff NB, Hobbs RE. Evaluation and management of Carney's complex; an illustrative case. *Cleve Clin J Med.* 1991;58:248-256.
41. Buchino JJ, Buchino JJ, Uhlenhuth ER. Large-cell calcifying Sertoli cell tumor. *J Urol.* 1989;141:953-954.
42. Carney JA, Toorkey BC. Myxoid fibroadenoma and allied conditions (myxomatosis) of the breast; a heritable disorder with special associations including cardiac and cutaneous myxomas. *Am J Surg Pathol.* 1991;15:713-721.
43. Vidaillet HJ Jr, Seward JB, Fyke FE III, Su WP, Tajik AJ. "Syndrome myxoma"; a subset of patients with cardiac myxoma associated with pigmented skin lesions and peripheral and endocrine neoplasms. *Br Heart J.* 1987;57:247-255.

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"Ovarian Asthma" — Fact or Fancy?

Martin Gotthardt, MD; J.D. Clark, MD; Thomas M. Roy, MD

Hormonal interactions have been suspected of worsening airways dysfunction in a subgroup of female asthmatics. Despite reports of fatal and near-fatal asthma attacks associated with menstruation, there is little consensus about the impact of this biologic function on the clinical expression of asthma. The authors present a young asthmatic female whose episodic and potentially fatal worsening of asthma typically occurred within the days prior to her menses in the absence of other trigger factors.

One of the earliest associations between menstruation and the exacerbation of asthma symptoms was described in 1938 by French investigators.¹ They reported a subgroup of 36 asthmatic females with documented deterioration of airway function before or during their menstrual period. The observation that oophorectomy had a beneficial effect in many patients seemed to confirm a causal interplay. Eighteen years later, Beaumont introduced to clinicians the descriptive term "ovarian asthma" to refer to the relationship between female physiologic function and asthma.²

It is currently proposed that approximately one-third of asthmatic females note worsening of their hyper-reactive airways disease just before or during their menses.^{3,4} The exacerbations of asthma attributed to the hormonal changes leading to menstruation have been severe enough to cause recurrent respiratory failure and death.⁵

Despite scattered reports that substantiate an association between asthma and menstruation, there has been little emphasis on this potential biochemical trigger in the actual care of asthmatic females. The research that has been done is often conflicting and fails to provide the clinician with a reasonable explanation for the proposed association nor a plan of action for securing the diagnosis when it is suspected.

Case Report

The patient is a 23-year-old Caucasian female who was admitted with her fifth episode of status asthmaticus in the past year. She failed to respond to aggressive treatment with inhaled and subcutaneous bronchodilators, and required intubation and mechanical ventilation for respiratory failure. She received intravenous corticosteroids, intravenous aminophylline, and continued inhaled bronchodilators. She was sedated and paralyzed during the first day on the ventilator because initial peak inspiratory pressures were higher than 80 cm of water.

On the second ventilator day the patient began her menses. The patient was weaned without difficulty on the fourth day as signs of increased airflow resistance abated. The peak expiratory flow rates after weaning were consistently greater than 300 LPM. During the 12 months prior to this admission the patient had required hospitalization for asthma on four other occasions. She had required intubation and mechanical ventilation on two of those admissions.

The patient's physical examination was unremarkable except for a slightly cushingoid appearance from chronic corticosteroid use. After extubation, minimal baseline wheezing was present on forced expiration. Cardiopulmonary exam was otherwise normal. Laboratory studies, electrocardiogram, and chest radiographs were normal.

She was diagnosed with asthma at age 15 years. She denied sinusitis, gastroesophageal reflux, or the use of over the counter medications. She had two brothers with mild asthma, but neither sibling had required hospitalization. She was compliant with a regimen of inhaled beta-adrenergics, inhaled cromolyn sodium, oral theophylline and oral corticosteroids.

The patient and her husband asked for a conference after extubation to discuss their observation that her asthma attacks were consistently more severe during the last few days prior to men-

struation. Review of her hospital records confirmed that her attacks occurred in the 3 to 5 days before the onset of menses. Her menarche occurred at age 12 years and she was in a regular cycle by age 13 years. She had used oral contraceptives from age 19 to 22 years, but had discontinued them 2 years ago. She had not required hospitalization for asthma until the last 12 months.

The patient was monitored with twice daily PEFR measurements and a symptom diary for 3 months. The PEFR measurements declined from a mean of 380 LPM to a mean of 220 LPM in the week before starting the menses. During the premenstrual period of the third month, the patient was admitted from the emergency room but did not require intubation. She was subsequently started on a combination oral contraceptive containing ethinylestradiol and norethindrone acetate. She has done well over the last 12 months without severe asthmatic symptoms or hospitalization. She is now well controlled with only inhaled corticosteroids and inhaled beta-2 agents.

Discussion

Prepubertal asthma admissions show a 2:1 male predominance, but there is a statistically significant higher incidence of female asthma admissions after puberty.⁶ In addition, female asthmatic patients experience longer hospital stays than their male counterparts.⁷ Such observations suggest that females may be more severely affected by hyper-reactive airways disease. It has been postulated that this may be explained by the hormonal and biochemical differences related to gender.⁷ In addition to the difference between female and male asthma severity, there also appears to be a subset of females whose symptoms are worse just before or at the time of menstruation. These individuals are said to have "premenstrual asthma" (PMA).

The diagnosis of PMA is predicted on demonstrating significant variation in airway function during the period just prior to the onset of menses. This is most easily documented by having the patient keep a daily diary of Peak Expiratory Flow Rates (PEFR). These values are measured at the same time each day in the morning and evening. In patients with PMA, the PEFR values show an overall decline in the days just before the onset of menses. Likewise a greater variance between morning and evening measurements is expected during this 3 to 5 day period. It has been proposed

that the women who are at the greatest risk of life-threatening asthma attacks can be identified by large diurnal swings in PEFR.⁵

The mechanism of worsening asthma severity in relation to menstruation is not known. Several interesting hypotheses have been offered, but none have uniformly explained the phenomenon.

Mood changes associated with premenstrual syndrome have been considered as a possible predisposing factor. It has been suggested that women with premenstrual asthma have a more severe premenstrual syndrome than other asthmatic women.⁸ If this is true, then the symptoms of asthma that occur during the premenstrual syndrome might be perceived as more problematic than at other parts of the cycle. The awareness of breathlessness (dyspnea) may be less tolerated due to additional malaise. A true increase in bronchomotor tone would then be accomplished via the vagal parasympathetic pathways as a result of heightened psychological input. This premise has never been proven.

In one large study, there was no correlation between premenstrual tension, irritability or depression and worsening asthma.⁹ Psychological unacceptance of the menses also seems unlikely in that most women who have PMA developed asthma in childhood, menarche in adolescence, but experience the premenstrual exacerbations of asthma at a mean age of 25 years.⁴ Neither menstrual cycle length nor the behavior of asthma during pregnancy correlates with the occurrence of premenstrual exacerbation of asthma.

In certain female asthmatics, worsening of symptoms could be caused by the ingestion of aspirin or nonsteroidal preparations for the relief of dysmenorrhea. It is well established that a small group of asthmatics experience adverse airway tone after taking medication that blocks the cyclooxygenase pathway. However, most women who are reported with premenstrual asthma have no such history of medication use.

Attempts to associate plasma hormone levels with the pattern of change in the recorded PEFR are logical. The obvious starting point would be examination of the cyclic variation of progesterone. The serum progesterone level peaks at 7 days before menstruation and then rapidly falls to undetectable levels at the onset of the period. Progesterone is acknowledged as a smooth muscle relaxant. It is hypothesized that the drop in the plasma progesterone level is associated with

withdrawal of the relaxant effect on bronchial smooth muscle with resultant bronchoconstriction.

Efforts to parallel the changes in bronchial reactivity to plasma concentrations of progesterone during the menstrual cycle are inconclusive. Bronchial responsiveness to methacholine in women with a normal menstrual cycle does not differ in the week before beginning menstruation and the week after. This time period corresponds with the highest and lowest cyclic progesterone concentrations.¹⁰ The study included 17 women with well-controlled asthma, but only 1 woman who thought she might have worsening asthma relating to the menstrual cycle. Airway responsiveness to histamine was also studied in 9 females with mild asthma and no history of PMA.¹¹ No significant difference in airway responsiveness could be demonstrated. Such studies introduce a selection bias by failing to include females who note significant circummenstrual asthma symptoms. They establish that physiologic changes in female hormones do not alter airway reactivity in normal or mild asthmatics. There are no similar studies in patients with severe asthma because of the confounding effects of concurrent medications, specifically corticosteroids.

Although a correlation was not established between methacholine responsiveness and progesterone levels, the authors comment that the asthmatic symptoms of the study group were universally worse during menstruation.¹⁰ This observation supports earlier studies that showed that asthma symptoms deteriorate just prior to and during the menses.^{3,4,9} The implication is that even female asthmatics who are not aware of menstrual-related respiratory symptoms may actually experience them.

If only females who make an association between their asthma and menstruation are examined, approximately 80% of these women subjectively rate their asthma as mild or moderate. They probably sustain no significant impairment in airflow that would bring them into the emergency room. On the other hand, about 20% of these females consider themselves to have severe asthma. It is this group that deserves the continued attention of the physicians, since it has been observed that severe asthmatics are more likely to develop PMA than mild asthmatics. In addition, they may be resistant to conventional therapy until the end of the menstrual period.⁴

The mean change in the serum progesterone level between the follicular and luteal phases

with natural menstrual cycles was approximately 30 ng/ml. It is possible that this degree of variation is not sufficient by itself to change airway responsiveness. Perhaps, a combination of biochemical changes better explains altered bronchomotor tone in PMA. Estradiol also reaches adult levels by age 16 years. Increased acetylcholine concentration, increased mucus secretion, and increased prostaglandin production have been associated with this hormone.¹² When the concentrations of estradiol, progesterone, and cortisol were evaluated in normal and asthmatic females, at least one of the plasma hormone levels was out of the normal range in 80% of those with hyper-reactive airways disease.¹³

Another possibility is that the effect of female hormones on the human airway do not relate to peak serum levels, but to falling levels. Withdrawal of progesterone allows increased excitability of smooth muscle and withdrawal of estradiol reduces sensitivity to endogenous catecholamines.

Finally, if we accept that physiologic hormonal variation is not the cause of PMA, then attention should be directed towards receptor status. Progesterone receptors are found in the nasopharyngeal passages and the lungs. They may become hyposensitive in certain individuals and require a pharmacologic rather than physiologic dose of progesterone for stimulation.¹⁴ It can also be demonstrated in vitro that 17 B-estradiol and progesterone potentiate the relaxation effect of exogenously administered B-agonists by influencing Beta-2 receptor density. It is presumed that decreases in these hormones could also diminish the effects of endogenous catecholamines, with worsening bronchomotor tone.

Prostaglandins are implicated in the pathogenesis of both asthma and dysmenorrhea. It is known that both inhaled and intravenous prostaglandin F₂-alpha induces bronchoconstriction in normal individuals and more so in asthmatics.¹⁵ This prostaglandin rises during ovulation and prior to menstruation. Monthly variations in this endogenous prostaglandin may modulate bronchial tone in conjunction with hormonal changes. It is suggested that the prostaglandin is not the sole factor in PMA since inhibition of prostaglandin synthesis does not prevent or ameliorate the asthmatic attacks.¹⁶

When the clinician identifies the patient with PMA, treatment decisions become difficult. The success of a particular therapeutic intervention has rarely been properly evaluated due to the

Ovarian Asthma

small number of individuals treated. Therapeutic interventions are based primarily on scattered case reports. Empiric therapy is employed because of the witnessed severity of the PMA.

Intramuscular progesterone has been used successfully in females with life-threatening PMA. The doses were significant and averaged 600 mg of depo-provera twice weekly.¹⁷ These treatments are effective, but may cause fluid retention and depression. Other investigators have had success with the suppression of gonadotropic hormones by a long-acting luteinizing-hormone releasing agonist, triptoreline. This form of chemical suppression is given every 28 days by intramuscular injection of 3.75 mg.¹⁸ Such treatment is associated with a predictable osteoporosis. Another therapy utilizes an oral contraceptive with a high progesterone to estrogen ratio. The combination of 20 mcg of ethinylestradiol and 1.0 mg of norethindrone acetate has been used successfully.¹⁹ This was the therapy selected in our patient and resulted in improvement in symptoms and reduction in oral corticosteroids.

In summary, the literature supports that premenstrual exacerbation of asthma may have important clinical relevance to the female with severe asthma.²⁰ Although the definitive causes of PMA are not yet understood, hormonal therapy appears to influence outcome in those women whose asthma is life-threatening. Continued investigations that include women with significant circamenstrual fluctuations in asthma symptoms will be needed to determine the pathophysiology and optimal treatment.

References

1. Claude F, Allemany Vall R. Asthme et menstruation. *Presse Medicale*. 1938;38:755.
2. Beaumont GE. Ovarian asthma. In: *The Clinical Approach to Medical Practice*. London: J. and A. Churchill, 1956.
3. Hanley SP. Asthma variation with menstruation. *Br J Dis Chest*. 1981;75:306-308.
4. Gibbs CJ, Coutts IL, Lock R, Finnegan OC, White RJ. Premenstrual exacerbation of asthma. *Thorax*. 1984;39:833-836.
5. Eliasson O, Scherzer HH. Recurrent respiratory failure in premenstrual asthma. *Conn Med*. 1984;48:777-778.
6. Eliasson O. The female to male ratio of hospital admissions for asthma. *Am Rev Respir Dis*. 1985;13(part 2):A110.
7. Skobeloff EM, Spivey WH, St. Clair SS, Schoffstall JM. The influence of age and sex on asthma admissions. *JAMA*. 1992;268:3437-3440.
8. Rees L. An etiological study of premenstrual asthma. *J Psychosom Res*. 1963;7:191-197.
9. Eliasson O, Scherzer HH, DeGaff AC, Jr. Morbidity in asthma in relation to the menstrual cycle. *J Allergy Clin Immunol*. 1986;77:86-94.
10. Juniper EF, Kline PA, Roberts RS, Hargreave FE, Daniel EE. Airway responsiveness to methacholine during the natural menstrual cycle and the effect of oral contraceptives. *Am Rev Respir Dis*. 1987;135:1039-1042.
11. Weinmann GG, Zacur H, Fish JE. Absence of changes in airway responsiveness during the menstrual cycle. *J Allergy Clin Immunol*. 1987;79:634-638.
12. Abdul-Karim RW, Drucker M, Jacobs RD. The influence of estradiol-17 on cholinesterase activity in the lung. *Am J Obstet Gynecol*. 1970;108:1098-1101.
13. Rubio RL, Rodriguez GB, Collazo JJ. Comparative study of progesterone, estradiol, and cortisol concentrations in asthmatic and nonasthmatic women. *Allergol Immunopathol (Madrid)*. 1988;16:263-266.
14. Nock B. Noradrenergic regulation of progestin receptors. New findings, new questions. In: *Reproduction — a behavioral and neuroendocrine perspective*. *Ann NY Acad Sci*. 1986; 474:15-22.
15. Mathe AA, Hedquist P. Effect of prostaglandins F2-alpha and F2 on airway conductance in healthy subjects and asthmatic patients. *Am Rev Respir Dis*. 1975;111:313-320.
16. Eliasson O, Densmore MJ, Scherzer HH, DeGraff AC. The effect of sodium meclofenamate in premenstrual asthma. A controlled clinical trial. *J Allergy Clin Immunol*. 1987;79: 909-918.
17. Benyon HLC, Garbett ND, Barnes PJ. Severe premenstrual exacerbations of asthma: effect of intramuscular progesterone. *Lancet*. 1988;2:370-372.
18. Perrin B, Bousquet J, Michel FB, et al. Severe premenstrual asthma. *Lancet*. 1988;2:843-844.
19. Morris D. Severe premenstrual asthma. *Lancet*. 1988;2:844.
20. Lenoir RJ. Severe acute asthma and the menstrual cycle. *Anesthesia*. 1987;42:1287-1290.

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Seat Belt Use in Kentucky

A Comparison of Five Measures

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Surveillance of seat belt use in Kentucky is of vital importance in the effort to reduce trauma from motor vehicle crashes. Self-report health surveys provide an important source for epidemiologic data on risk factors associated with non-use of seat belts. However, estimates of the prevalence of seat belt use derived from such surveys are consistently higher than estimates obtained from observational studies. In the 1993 Kentucky Health Survey, we introduced a new question designed to narrow the gap between observed and self-reported seat belt prevalence. The new question, which asked what percent of the time seat belts are worn, was compared with a "traditional" question, which asked persons to describe their frequency of seat belt use as "always," "nearly always," "sometimes," "seldom," or "never." Of the 652 persons answering both questions, 65.4% stated that they "always or nearly always" used a seat belt — a prevalence which was close to that reported by two other 1993 self-report studies: the Kentucky Behavioral Risk Factor Surveillance System and the Kentucky Health Interview and Examination Study. However, only 44.8% claimed to wear a belt "100%" of the time — a prevalence much closer to the 41% of Kentuckians observed to wear seat belts in the same year. We recommend that health surveys adopt this new question and accept nothing less than "100%" as defining a seat belt user. We also recommend that physicians use the new "percentage" question when counseling patients on seat belt use.

About 800 persons die each year in Kentucky from motor vehicle crashes.¹ In 1990, the motor vehicle-related death rate for Kentucky (22.9/100,000) exceeded the national average by 24%.² Failure to wear seat belts is a major risk factor leading to this excessive rate. Of the drivers killed on Kentucky roads from 1988 through 1992, 86.5% were not wearing seat belts.³ These grim

statistics underscore the importance of surveillance and intervention efforts that monitor and promote the use of seat belts on Kentucky roadways.

Each year, three separate statewide surveys measure the prevalence of seat belt use. Two of these are telephone surveys. The Kentucky Division of Health Services samples about 2000 persons through the Behavioral Risk Factor Surveillance System (BRFSS). Respondents are asked to choose which one of five adverbs, or frequency descriptors, best describes how often they wear a seat belt: "always," "nearly always," "sometimes," "seldom," or "never." Persons who answer "always" or "nearly always" are considered seat belt users.⁴ The University of Kentucky Medical Center conducts the Kentucky Health Survey (KHS), which has an annual sample size of about 650. Questions about seat belt use in the KHS follow a format that is identical to that of the BRFSS. In addition to these self-report surveys, the Kentucky State Police sponsor a survey in which about 100,000 vehicles are observed to determine the percent of drivers and passengers that wear seat belts.⁵

Fig 1 illustrates the comparison of the prevalence of seat belt use obtained from these three surveys from 1990 through 1992. The two self-report telephone surveys consistently show prevalences that exceed observed seat belt use by 18 to 28 percentage points.

Although overstatement of seat belt use in self-report data was first documented in 1969,⁶ risk factor surveys in Kentucky and elsewhere continue to include self-report questions on seat belt use.^{7,8} Because of the large gap between observed and self-reported seat belt use, the inclusion of self-report seat belt questions in surveys has been severely criticized in recent public health literature.^{9,10} However, epidemiologists and public health officials find these surveys valuable because they provide health and sociodemographic data which researchers can use to char-

acterize persons who do not wear seat belts.^{11, 12} It is therefore important to explore ways to improve the validity of self-report questions on seat belt use.

We hypothesize that the overestimation of seat belt use in telephone surveys is partially due to the *wording* of the question, not the fact that the estimates are based on self-report. Research has demonstrated that the interpretation of the adverbs commonly used as frequency descriptors is subject to wide variation.^{13, 14} It is not surprising, then, that the subjective estimates of seat belt use obtained from these "traditional" questions do not closely correspond to the objective measures obtained from observational studies.

In our study, we address the problem of the gap between observed and self-reported estimates of seat belt use by introducing a differently worded question that asks respondents to give the *percentage* of time they wear seat belts. We hypothesize that this question, which requires a quantitative answer, will provide an estimate of seat belt use which more closely corresponds to the observed prevalence than estimates obtained from the "traditional" question that uses imprecise frequency descriptors.

Methods

Data were collected by the University of Kentucky Survey Research Center in July 1993, as part of the Kentucky Health Survey. Sampling of households was accomplished through a random digit dial procedure.¹⁵ Trained telephone interviewers asked one adult in each contacted household to complete an 18-minute survey containing questions on health behavior and opinions related to injury and illness topics, plus questions on socio-demographic factors such as age and gender. The survey included two questions about seat belt use. The first of these questions had been used in the KHS since 1990: "How often do you wear a seat belt when driving or riding in a car? Would you say: always, nearly always, sometimes, seldom, or never?" About 3 minutes later in the survey, the interviewer asked a second seat belt question, written specifically for the present study: "What percent of the time do you wear a seat belt when driving or riding in a car?" The telephone interviewer did not offer any response categories for this second question and recorded the respondent's answer as a percent from zero to 100. Responses to all questions were entered into a computer-assisted telephone interview sys-

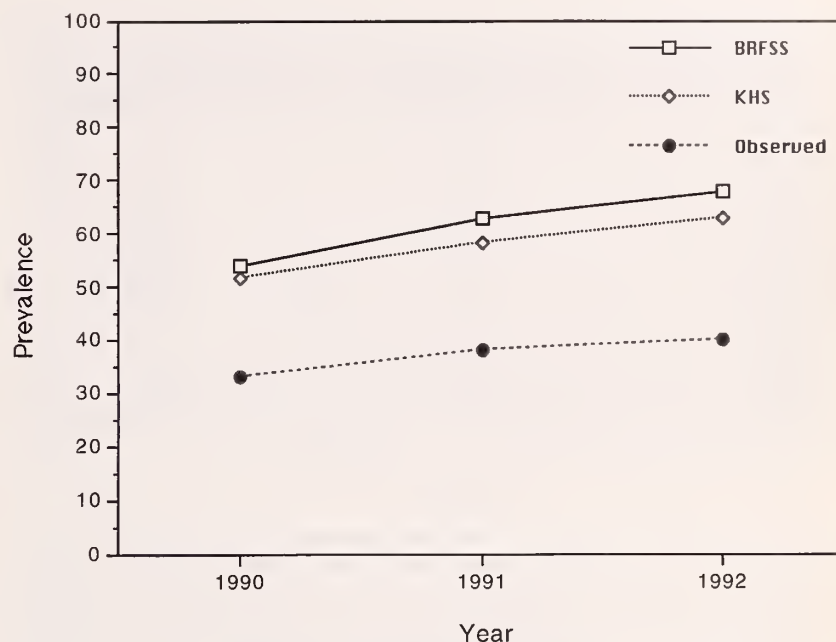


Fig 1 — Observed vs Self-Reported Seat Belt Use in Kentucky, 1990-1992

tem (CATI) at the time of the interview.¹⁶ Frequency distributions and summary statistics were computed for both of the questions, using SAS software.¹⁷

The Kentucky Department for Health Services provided us with the results of two self-report surveys which they had conducted in 1993, in which they asked the same seat belt question with the same five frequency descriptors. The Kentucky BRFSS, part of a national telephone survey conducted by the Centers for Disease Control and Prevention, randomly sampled over 2400 persons throughout Kentucky in 1993. The Kentucky Health Interview and Examination Study (KHIES), a one-time study to determine the health status of Kentucky's population, conducted telephone interviews on a sample of over 6000 persons, followed by voluntary clinical screening of over 1900 persons. Of these, 1356 were adults age 18 or over who answered the seat belt question. (M. Fazey, personal communication, October 6, 1995: Cabinet for Human Resources, Adult Health Branch, Department for Health Services, Frankfort, Kentucky.) The results of this study were released in the summer of 1995.¹⁸

We also obtained the results of the 1993 Kentucky State Police observational study of seat belt use.³ We compared this estimate with the four self-report measures (two from the KHS, one from the BRFSS, and one from the KHIES).

Seat Belt Use in Kentucky

Table 1. Distribution of responses to the percent-of-use seat belt question

| Percent of Use | Number of responses | Cumulative % of responses |
|----------------|---------------------|---------------------------|
| 0 | 72 | 11.0 |
| 1-9 | 28 | 15.3 |
| 10-19 | 29 | 19.8 |
| 20-29 | 19 | 22.7 |
| 30-39 | 9 | 24.1 |
| 40-49 | 7 | 25.2 |
| 50-59 | 56 | 33.7 |
| 60-69 | 8 | 35.0 |
| 70-79 | 17 | 37.6 |
| 80-89 | 27 | 41.7 |
| 90-99 | 91 | 55.2 |
| 100 | 292 | 100.0 |

We limited our focus to 1993 for two reasons: (1) We had five measures of seat belt use — more than in any other year; and (2) we expected that both observed and self-reported seat belt use would increase markedly after the state's mandatory seat belt law became effective in July 1994, thus affecting the comparability of data collected before and after that date.

Results

A total of 661 persons completed the 1993 Kentucky Health Survey; of these, the 652 who answered both questions about seat belt use were included in this analysis. The sociodemographic characteristics of the sample were generally representative of Kentucky residents 18 years of age or older.¹⁹

In response to the "percent-of-use" question, 44.8% of the people (95% confidence interval = 41.0–48.6) said they wore seat belts "100%" of the time (see Table 1). Responses ranged from "0%" to "100%" (mean = 69.8, standard deviation = 38.9, median = 95, mode = 100).

Fig 2 shows the distribution of responses to the traditional "frequency descriptor" seat belt question. Nearly half of the people said they "always" wore a seat belt, and a total of 65.4% said they "always" or "nearly always" wore a seat belt.

Fig 3 illustrates the comparison of the prevalences obtained by the five different measures: the two KHS questions, the Kentucky BRFSS, the KHIES, and the Kentucky State Police's observational study. For the three self-report surveys relying on the "traditional" question, users are defined as those who "always" or "nearly always" wear belts. For the new question, users are defined as people who say they wear a seat belt

"100% of the time." The figure shows that for the "traditional" question, prevalences are 24 to 25 percentage points above the observed prevalence for 1993. However, with the new question, the gap between observed and self-reported seat belt use is narrowed to less than 4 percentage points.

Discussion

While at least three other studies^{20, 21, 22} have asked persons to estimate their seat belt use as a percentage, ours is the first known study to use a randomly selected statewide sample to compare this measure with observed measures and other self-report estimates.

Our results suggest that the discrepancy between observed and self-reported prevalence of seat belt use derived from statewide surveillance studies could be reduced if persons managing health surveys instituted two changes: (1) seek the percent of time that belts are worn; and (2) define only those persons answering "100%" as seat belt users. When we introduced these changes in the Kentucky Health Survey, the number of people defined as "users" of seat belts was one third less than the number obtained with the survey's traditional self-report seat belt question. Correspondingly, the difference between self-reported prevalence and that observed by the Kentucky State Police was reduced by more than 20 percentage points.

The combining of "always" and "nearly always" responses to define seat belt users is taken from published reports of the BRFSS and the KHIES.^{4, 18} We used the same definition for the KHS for the sake of comparability. One might ask, why not retain the "traditional" question but limit the definition of seat belt users to only those who answered "always"? While this would obviously result in lower, more accurate prevalence estimates, our data indicate that making this change would still yield an estimate of seat belt use that is almost 20% higher than the observed estimate. Our new "percentage" question narrows that gap by more than half.

Our results must be interpreted in light of several study limitations. Reliance on a single cross-sectional survey limited our ability to test the reliability of the new question. While the reliability of the "traditional" seat belt question is evident from the stable percentage of users (65.8% \pm 0.4) obtained from the three studies in 1993, we do not have any repeated measures to assess

the reliability of the new question. However, internal consistency in this sample was high: 98% of the 292 persons answering "100%" said they "always" wore a seat belt.

An equally important issue is the validity of the prevalence we obtained with the new percentage question. Our estimates may be slightly inflated due to the inherent sampling bias in telephone surveys. Approximately 10% of households in Kentucky do not have a residential phone line;¹⁹ these households were automatically excluded from the KHS. The prevalence of seat belt use reported by the Kentucky State Police, on the other hand, included observations of persons both with and without telephones. Persons without telephones, compared with those who do have telephones, are more likely to have poorer health practices and less knowledge of correct health practices, and are less likely to wear seat belts.²³ One study found that seat belt use among persons in households without a telephone was half that of people with telephones.⁷ Had we been able to include persons without telephones in the KHS, the prevalence of seat belt use would likely have been lower, making it even closer to the observed prevalence.

This study has implications for the role of physicians in the primary prevention of motor vehicle injuries. While the state's seat belt law, in effect since July 1994, is an example of a "community-wide" approach to preventing motor vehicle injuries, the benefits of individual physician-patient and physician-family counseling to encourage and reinforce seat belt use should not be overlooked. Hunt recently characterized the failure of physicians to encourage safety belt use as a "missed opportunity in clinical preventive medicine."²⁴ Since the mid-1980s, physician counseling to urge patients to use seat belts and other occupant restraints has been recommended by the American Medical Association, the American Academy of Pediatrics, and the American College of Obstetricians and Gynecologists.²⁵ The 1994 report of the US Preventive Services Task Force recommends that "all patients should be advised to use safety belts when operating or riding in a motor vehicle."²⁶ That recommendation did not address the question of how physicians were to assess the need for counseling. We encourage physicians to ask what *percentage* of the time, rather than *how often*, the patient wears a seat belt. Patients answering anything less than 100% might then be questioned as to their reasons for not wearing seat belts and offered specific coun-

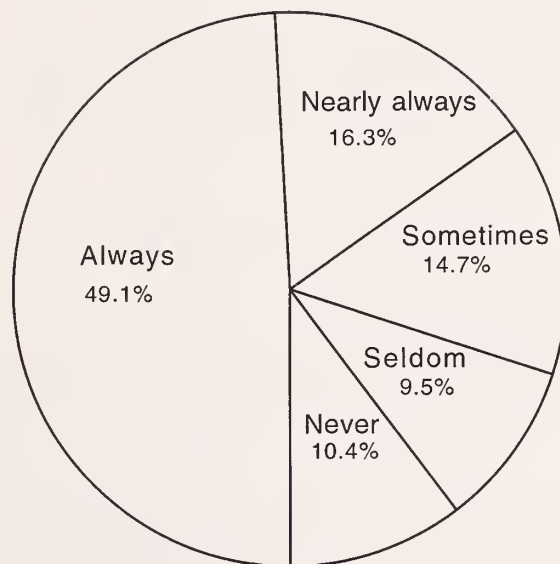


Fig 2 — Self-reported seat belt use: Kentucky Health Survey, 1993

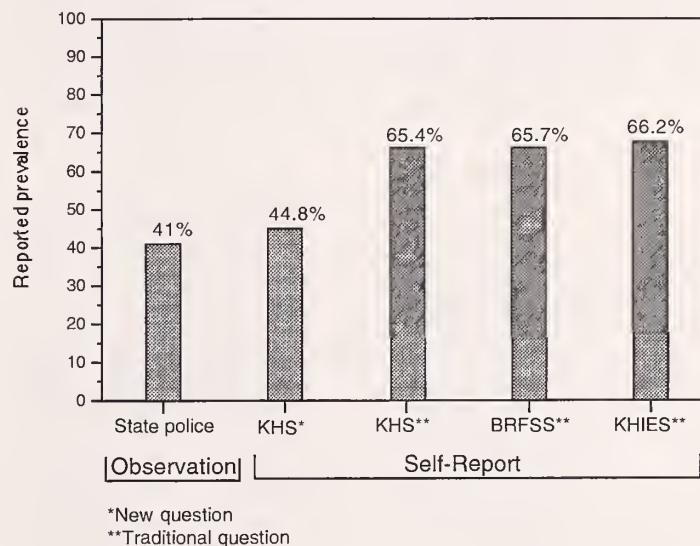


Fig 3 — Seat Belt Use in Kentucky, 1993: Five Different Measures

seling to persuade them to use belts 100% of the time.

We offer several recommendations for future research in Kentucky. First, we recommend that our new question be included annually in the KHS and in the Kentucky BRFSS, along with the "traditional" adverbial response question. This will allow the reliability of the new question to be assessed and permit additional analyses between

Seat Belt Use in Kentucky

the two questions. This is especially important now that Kentucky has a mandatory seat belt law for everyone. The effect of the law upon changes in seat belt use as measured by both adverbial response categories and percentages could be detected.

Hunter provides a methodology used in North Carolina that could be adapted in Kentucky.²⁷ A subsample of drivers in the Kentucky State Police's observational study could be followed up by telephone or mail to collect self-report data on belt use, using both the traditional and the new percentage question. Such a study would permit us to assess the validity of the new question without any sampling bias.

Motorists who wear seat belts anything less than 100% of the time are "at-risk" and need to be included in prevention programs. This new question will result in a modified risk profile for non-use of seat belts and will enable public health officials to develop programs that target audiences that fit this stricter definition of "non-user." Physicians can play an important role in this expanded prevention effort by learning to recognize "at-risk" patients and by encouraging seat belt use for *each and every time* a patient travels in a motor vehicle — in other words, 100% of the time.

References

1. Kentucky State Center for Health Statistics. *Kentucky Annual Vital Statistics Report, 1993*. Frankfort, KY: Department for Health Services. n.d.
2. National Center for Health Statistics. *Injury mortality: National Summary of Injury Mortality Data 1984-1990*. Hyattsville, Maryland: Public Health Service, 1993.
3. Agent KR. *1993 safety belt usage survey and evaluation of effectiveness in Kentucky*. Research Report KTC-93-21. Lexington, KY: Kentucky Transportation Center. College of Engineering. University of Kentucky, 1993, pp 20-27.
4. Kentucky Department for Health Services. *Kentucky Behavioral Risk Factor Surveillance, Combined Data 1991-1993, Executive Summary*. Frankfort, KY, 1994.
5. Agent KR. *1995 Safety Belt Usage Survey and Evaluation of Effectiveness in Kentucky*. Research Report KTC-95-20. Lexington, KY: Kentucky Transportation Center, 1995.
6. Waller PF, Barry PZ. *Seat belts: a comparison of observed and reported use*. Chapel Hill, NC: The University of North Carolina Highway Safety Research Center, 1969.
7. Peterson DE, Remington PL, Kuykendall MA, Kanarek MS, Diedrich JM, Anderson HA. Behavioral risk factors in Chipewewa Indians living on Wisconsin reservations. *Public Health Rep*. 1994;109:820-823.
8. Piani AL, Schoenborn CA. Health promotion and disease prevention: United States, 1990. Data from the National Health Survey. National Center for Health Statistics. *Vital Health Stat*. 1993;10(185):11-12, 64.
9. Robertson LS. The validity of self-reported behavioral risk factors: seatbelt and alcohol use. *J Trauma*. 1992;32:58-59.
10. Robertson LS. Self-reports yield invalid results on seat belt use [letter]. *Am J Public Health*. 1994;84:1525-1526.
11. Helsing KJ, Comstock GW. What kinds of people do not use seat belts? *Am J Public Health*. 1977;67:1043-1050.
12. Hunt D, Lowenstein SR, Badgett RG, Marine WM, Garrett CJ, Steiner JF. Detection of injury-prone behaviors among internal medicine patients. *J Gen Intern Med*. 1992;7:573-582.
13. Kenney RM. Between never and always. *N Engl J Med*. 1981;305:1097-1098.
14. Toogood JH. What do we mean by "usually"? *Lancet*. 1980;1:1094.
15. Waksberg J. Sampling methods for random digit dialing. *J Am Stat Assoc*. 1978;73:40-46.
16. Nicholls WL II. Computer-assisted telephone interviewing: a general introduction. In Groves RM, Biemer PP, Lyberg LE, Massey JT, Nicholls WL II, Waksberg J, eds. *Telephone Survey Methodology*. New York: John Wiley & Sons; 1988:377-385.
17. SAS Institute Inc. *SAS Procedures Guide*. Release 6.03 Edition. Cary, NC: SAS Institute Inc., 1988.
18. Finger R, Stapleton M, Mendiola M, Spears E. *Kentucky Health Interview and Examination Survey 1993*. Frankfort, KY: Kentucky Department for Health Services; June 1995.
19. Bureau of the Census, US Department of Commerce: *1990 Census of Population: General Population Characteristics, Kentucky*. Washington, DC: Government Printing Office, 1992.
20. Larmon B, LeGassick TF, Schriger DL. Differential front and back seat safety belt use by prehospital care providers. *Am J Emerg Med*. 1993;11:595-599.
21. Bechtel GA, Franklin R. Health risk appraisal of differences between well elderly and university students. *J Community Health Nurs*. 1993;10:241-247.
22. Gottlieb NH, Weinstein RP, Bawn WB, Bernacki EJ. A profile of health risks among blue-collar workers. *J Occup Med*. 1992;34:61-68.
23. Thornberry OT Jr, Massey JT. Trends in United States telephone coverage across time and subgroups. In: Groves RM, Biemer PP, Lyberg LE, Massey JT, Nicholls WL II, Waksberg J, eds. *Telephone Survey Methodology*. New York: John Wiley & Sons; 1988:25-49.
24. Hunt D, Lowenstein SR, Badgett RG, Steiner JF. Safety belt nonuse by internal medicine patients: A missed opportunity in clinical preventive medicine. *Am J Med*. 1995;98:343-348.
25. US Preventive Services Task Force. *Guide to Clinical Preventive Services: an assessment of the effectiveness of 169 interventions*. Report of the US Preventive Services Task Force. Baltimore, MD: Williams & Wilkins; 1989:317-318.
26. Office of Disease Prevention and Health Promotion. *Clinician's Handbook of Preventive Services*. Washington, DC: Government Printing Office, 1994:292.
27. Hunter WW, Stewart JR, Stutts JC, Rodgman EA. Observed and self-reported seat belt wearing as related to prior traffic accidents and convictions. *Accid Anal Prev*. 1993;25:545-554.

The Kungsholm

My father was a good man. My mother was an intriguing and fun woman. His father was a Pentecostal Christian and her father was a handsome, prototypical Alzheimer's bat.

In 1955, while living in a barracks apartment with a pretty young mother and an exasperating colicked first born at the US Naval Hospital, Great Lakes, my mother proposed to meet us for dinner in Chicago. Entering the Kungsholm was an exciting 1930's movie thrill. My mother sat (against the law in Kentucky) at the bar sipping an old fashioned, looking Myrna Loy beautiful and sophisticated. Joining her made us feel like the privileged Prince and Princess; dinner during the puppet performance of Cavalleria Rusticana completed the fairy tale and my mother vanished to I remember not where and we returned to grunge.

It seemed so right to smoke a cigarette, degust an exquisitely dry martini, feast on red rare beef and wish one had entree to the casino about which everyone knew but no one, a navy lieutenant and not even a Cincinnati grandame, could enter.

My paternal grandfather was described by his son as a rock farmer. His morals were strict and pure. He would grow, but never smoke, tobacco. He would grow, but never drink, corn. The only thing more immoral would be gambling, although he did put 10% of not much in the

collection plate. What is the Las Vegas line on that one?

After all these years spent in glorious sinning and hard won virtues

"Tobacco is deadly. Alcohol is ruinously brain numbing. Gambling reduces gamblers and their families to wretched social burdens and unfulfilled promises."

via abstentions, I am maturing into unexpected agreement with my grandpappy, who also criticized "that spo'ts cyar" but which I always suspected he admired. Tobacco is deadly. Alcohol is ruinously brain numbing. Gambling reduces gamblers and their families to wretched social burdens and unfulfilled promises.

The inexcusable blessing and encouragement our wise and paternal governments are giving to gambling is incredibly shortsighted. The results of these bright, flourishing marvels will be fiscally and morally eroding.

A. Evan Overstreet, MD
Editor

Fee-Based Financial Planning Services

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A COMMUNITY CHALLENGE

19th Annual National Conference
National Rural Health Association
May 15 - 18, 1996
Minneapolis, Minnesota



Marla Vieillard

Congress and President Clinton are battling over the balanced budget and the future of Medicare. Everyone is concerned about the care of our senior citizens, our families and children, and future generations. Our State Legislature is battling over Kentucky's Health Care Reform revisions and the repeal of the provider tax. Yet, our spouses struggle with these issues and still continue to provide the best medical care known in a free enterprise society. DOCTORS' DAY is March 30th this year and every year to come.

The first Doctors' Day observance was held on March 30, 1933, by the Barrow County Auxiliary in Winder, Georgia. Mrs Eudora Brown Almond, wife of Dr Charles B. Almond, had the idea to set aside this day. The recognition occurred on the anniversary of the first administration of ether anesthesia by Dr Crawford W. Long in Barrow County, Georgia, in 1842. The first observance included the mailing of cards to the physicians and their wives, flowers placed on the graves of deceased doctors, including Dr Long, and a formal dinner in the home of Dr and Mrs William T. Randolph.

Next, the Barrow County Auxiliary presented the adopted Barrow County Doctors' Day resolution to the Georgia

State Medical Auxiliary in 1933. On May 10, 1934, the resolution was adopted at the annual state meeting in Augusta, Georgia. The resolution was introduced to the Women's Medical Auxiliary of the Southern Medical Association at its 29th annual meeting, November 1935. Since then, Doctors' Day has become synonymous with the Southern Medical Association Auxiliary. The red carnation has been used as the Doctors' Day symbol.

On March 30, 1958, a Resolution Commemorating Doctors' Day was adopted by the United States House of Representatives. On August 1, 1989, the SMA Auxiliary dedicated a bronze marker honoring Mrs Almond on the grounds of the Court House in Winder, Georgia. In 1990, legislation was introduced in the House and Senate by representatives Mike Parker and G. V. Montgomery and Senator Thad Cochran to establish a National Doctors' Day. This legislation received overwhelming approval in both houses, and on October 30, 1990, President George Bush signed SJ RES #366, which became public law 101-473 designating March 30th as "National Doctors' Day." This was the culmination of the efforts of auxiliaries/alliance members across the country, led by SMAA Presidents, Mrs A. J. Campbell and Mrs Jim Barnett.

Our physicians deserve this honor for their hard work, dedication, sacrifice, and physical and emotional stress of the profession. Their families deserve the second honor for helping meet their goals and understanding the demands medicine makes on a family. The national holiday may make more people stop and think about the care they receive, and their physicians who help maintain their wellbeing. We have holidays to past Presidents, religious activists, and to honor those lost in time of war. Our Alliance members must seek ways to make this day known to the media, remind hospital

Doctors' Day

administrators, and publicly encourage people to show appreciation for the roles our spouses take in caring for their families, seeking the latest medical knowledge and updates to promote good health and care. They deserve to be honored especially in these volatile times of health care reform.

We are no longer in the Doc Holiday medicine era. We've come a long, long way to a techno-computer-assisted-gene splicing-multi-drug-family era. The end to advances is not in sight but the funds may be. It is pathetic that a cab driver is paid 40% more than the physician who delivers care to the Medicaid patient. The physician, 20-30 years ago, was respected and trusted. He/She may have received something else besides \$\$\$ for their services, but they did not have the expenses of malpractice insurance that has risen as rapidly as recent health insurance premiums, or high office maintenance and management expenses. These medical advances have brought with them the Age of Resignation (low self-esteem, why fight the legal system, the legislature is out to get us). Our physicians are not honored or respected as in the past. Their days are no shorter, and their lives may not be any longer.

With all these changes, now more than ever, we need to have public awareness of March 30, 1996, as National Doctors' Day. Physicians need their day in the spotlight and a thank you for all they do for us.

From the Kentucky Medical Association Alliance to all Kentucky Physicians, we are behind you now and in the future. We honor you for your care and concern for patients, and those physicians' spouses who work so hard to support the many causes of medicine and health-related issues.

Marla Vieillard
KMAA President

New Officer Profiles

During the 1995 KMA Annual House of Delegates meeting held in Lexington, four new officers were elected to serve on the Board of Trustees. KMA congratulates the following members on their election and thanks them for their valuable leadership.



Baretta R. Casey, MD, a family physician in Pikeville, was elected to serve a 2-year term as an Alternate Delegate to the AMA and a 3-year term as KMA Alternate Trustee for the 14th District.

Dr Casey began active involvement with the KMA in 1986 in the Medical Student Section and served in numerous positions prior to being elected KMA-MSS Governing Council President in 1990. She is a member of the KMA Physician Workforce, Young Physicians Steering, and Community and Rural Health Committees, as well as chairperson of the Subcommittee on Domestic Violence. A member of the AMA National Coalition of Physicians Against Family Violence, Dr Casey received the 1995 AMA-YPS Community Service Award for her work in domestic violence. She

served as a member of the Commonwealth of Kentucky — Governor's Task Force on Domestic Violence Crime in 1995, and currently is chairperson of the Pike County Domestic Violence Board. She served as a KMA Delegate for Pike County in 1995.

A native of Kentucky, Dr Casey, 42, graduated cum laude from Pikeville College in 1984. She earned her MD from the University of Kentucky College of Medicine in 1991, followed by an internship (1991-92) and family practice residency (1992-94) at the Trover Clinic Foundation-Regional Medical Center.

She is in a solo practice and has privileges at Pikeville Methodist Hospital.

Dr Casey and her husband, Mike, reside in Pikeville. They have three children and one grandchild.



Charles R. Dodds, MD, an Earlington family physician, was elected to serve a 3-year term as Third District Trustee.

A member of KMA since 1965, Dr Dodds served annually as a KMA Delegate for Hopkins County from 1980 until 1990. Current service includes membership on the Community and Rural Health Committee. Dr Dodds is a past president of the Kentucky Academy of Family Physicians and served on the KAFP Board of Directors in 1980-86. He is a fellow of the American Academy of Family Physicians and a diplomate of the National Board of Medical Examiners.

A native of Alabama, Dr Dodds, 51, earned his undergraduate degree

from Memphis State University, Memphis, TN, in 1967 and his MD from the University of Tennessee College of Medicine in 1971.

Postgraduate education included completion of an internship at the Medical Center of Central Georgia, Macon, in 1972, and a family practice residency at Hopkins County Hospital — Trover Clinic in 1974.

He is a staff physician at Trover Clinic and has privileges at the Regional Medical Center of Hopkins County, where he served as Chief of Staff in 1983.

Dr Dodds and his wife Beryl, a past president of the KMA Alliance, are the parents of three sons. They reside in Madisonville.

KMA Board of Trustees

J. Michael Pulliam, MD, was elected to serve a 3-year term as Sixth District Trustee.

An active member of KMA since 1974, Dr Pulliam began service as a KMA Delegate for Simpson County in 1975 and has served as a Delegate for 11 of the past 20 years. He served as an Alternate Trustee for the Sixth District from 1979 to 1985 and 1993 to 1995.

A family physician, Dr Pulliam practices in Franklin. He earned his undergraduate degree at Centre College, Danville, in 1966 and returned to his native city to achieve his MD at the University of Louisville School of Medicine, class of 1970.

Postgraduate education included an internship at St Elizabeth Hospital, Covington, in 1970-71. He subsequently served in the US Navy from 1971 to 1973, including one year as Senior Medical Officer, Naval Ordnance Station, Maryland.

Dr Pulliam, 51, is a diplomate of the American Board of Family Practice, a member of the Simpson County Board of Health, and a past president and member of the Board of Trustees of Franklin-Simpson Memorial Hospital, where he has privileges.

Residents of Franklin, Dr Pulliam and his wife, Sylvia, are the parents of two daughters.



Eugene H. Shively, MD, a general surgeon practicing in Campbellsville, was elected to serve a 3-year term as Fourth District Trustee.

An involved member of KMA since 1974, Dr Shively served as a KMA Delegate for Taylor County in 1982 and from 1990-95. He is a past member of the Interspecialty Council and currently serves on the Pro Advisory Committee. He is extensively involved in several professional and civic organizations including Southeast Surgical Congress, Society American Gastrointestinal Endoscopic Surgeons, Christian Medical Society, Southern Surgical Association, American Society of General Surgeons, and is a past president of the Hiram Polk Surgical Society.

Dr Shively, 51, is a native of Lebanon, Kentucky. He earned his undergraduate degree in 1966 and medical degree in 1970 from the University of Louisville, followed by a residency at the University of Cincinnati Affiliated Hospitals in 1970-71 and a general surgery residency at the University of Louisville in 1973-77. He served in the US Air Force in 1971-73 as a flight surgeon at USAF Hospital, Forbes AFB, Kansas.

He is an active past president of the medical staff at Taylor County Hospital, and also has privileges at Jane Todd Crawford, Westlake Cumberland, and Springview Hospitals.

Dr Shively and his wife, Susan, reside in Campbellsville. They have two children.



PEOPLE

Robert G. Overstreet, MD, has been elected chief of staff at The Medical Center of Southern Indiana, Charlestown, and **Koduvathara James, MD**, was elected vice chief of staff.

UPDATES

Coalition Launches Statewide Campaign for Medical Research

Leaders in health care, business, education and government gathered recently to launch Research!Kentucky, a grass-roots campaign designed to increase awareness of the value and impact of medical research in this state.

"With such intense focus on the delivery of health care, including the debate on Medicare and Medicaid, America has lost sight of the importance of medical research in developing more effective treatments that lower overall health care costs, improve quality of life, and generate substantial economic growth in the communities where research takes place," said **Dr Donald Kmetz**, Research!Kentucky Co-Chair.

Research!Kentucky is a coalition among The Universities of Louisville and Kentucky, the state Economic Development Cabinet, Research!America, and dozens of business and community leaders, all of whom are committed to communicating the important social and economic roles that medical research plays in Kentucky. Research!America is a national non-profit organization that conducts public education for medical research on a national level.

Only three cents of every health care dollar are spent on medical research, and more is spent on health care in ten days than what is spent on

medical research in an entire year. Just a few years ago the National Institutes of Health, a primary source of funds for university-based medical research in the US, was able to fund about half of all approved projects. However, flat funding levels for the federal agency, combined with continued increases in inflation, has diminished NIH spending power, and last year only two in ten approved projects were funded.

Research!America and Research!Kentucky exist to educate citizens about these dangerous signs that America's role as the undisputed world leader in medical research is slipping, and to encourage citizens to demand that medical research be a higher national priority.

"The Research!Kentucky campaign features a number of statewide activities designed to increase awareness of the value and impact of medical research, to generate dialogue about medical research, and to stimulate children's interest in a career in the sciences," said **Dr Emery Wilson**, Research!Kentucky Co-Chair. Included are a speakers bureau, public service announcements, and a "Scientists in the Schools" program that brings researchers into middle school classrooms.

Kentucky is only the fourth state to sponsor such a program, following campaigns in Maryland, North Carolina, and metro New York.

KMA Immediate Past President, **Dr Robert Goodin**, is KMA's representative to Research!Kentucky.

For more information about Research!Kentucky contact Laura C. Dawahare, Project Director, at 606/233-3342.

HCFA Issues 1996 Updates to Physicians

HCFA recently announced its 1996 fee schedule updates to physicians, with an average increase of 0.8 percent,

according to a final notice which appeared in the December 8 *Federal Register*.

The updates, which were effective January 1, 1996, are 3.8% for surgical services, -2.3% for primary care services, and 0.4% for other non-surgical services, according to the notice.

The Medicare Volume Performance standards rates of increase, which were effective October 1, are 0.5% for surgical services, 9.3% for primary care services, and 0.6% for other nonsurgical services — a weighted average of 1.8% for all physicians' services, HCFA said in the notice.

The 1996 conversion factors are \$15.28 for anesthesia services, \$40.7986 for surgical services, \$35.4173 for primary care services, and \$34.6293 for other nonsurgical services.

Congress did not set the updates for 1996 based on recommendations submitted in May by Health and Human Services Secretary Donna E. Shalala, so the default updates, the formulas which are set in the law covering Medicare's payment of physicians, were implemented.

In calendar year 1995, updates were 12.2% for surgical, 7.9% for primary care, and 5.2% for other non-surgical.

Outpatient diagnostic laboratory tests paid through intermediaries are included in the MVPS for the first time beginning in fiscal 1996. Also beginning in fiscal 1996, HCFA will use category-specific volume and intensity growth allowances in calculating the default VPS, the rule said.

For further information on the final rule, contact HCFA at 410/786-4586 or 410/786-5617.

Medicaid Claims Processing Update

KMA leadership and staff continue to meet with UNISYS representatives and

Patton Administration officials in an attempt to expedite efforts by UNISYS to become fully operational in its Medicaid claims processing. Frequent meetings will be held until all glitches in the system are removed and UNISYS begins to quickly and fairly process physician Medicaid claims.

Please advise KMA staff of any ongoing problems you may be having with UNISYS and these concerns will be communicated to UNISYS. Any additional concerns/questions regarding UNISYS can be directed to their toll free number at 1-800/807-1232.

Kentucky Organic Growers

At the 1995 KMA Annual Meeting in September, the House of Delegates adopted Resolution Q — Kentucky Organic Growers. The Kentucky Organic Growers is a pilot program developed by the Burley Tobacco Growers Cooperative Association which is in its second year. The Kentucky Organic Growers develops networks between consumers and producers of organic crops.

Resolution Q recommends that KMA continue to show support for the Kentucky Organic Growers and the Commodity Growers Cooperative Association by educating patients and the community regarding the connection between health and agriculture, and support the efforts to expand marketing opportunities for Kentucky farmers and encourage public support for the consumption of locally produced goods.

Task Force Formed to Study House Bill 250

The Governor and leadership of the Kentucky General Assembly have formed the bipartisan task force to develop recommendations to "reform" House Bill 250. The task force is composed of House Speaker

Jody Richards, House Majority Floor Leader Greg Stumbo, House Minority Floor Leader Danny Ford, and Representative **Ernest L. Fletcher, MD**. The Senate will be represented by President John "Eck" Rose, Majority Floor Leader David Karem, Minority Floor Leader Dan Kelly, and Senator **James D. Crase, MD**. In addition, Governor Patton and Lieutenant Governor **Stephen L. Henry, MD**, serve on the task force. The task force met for the first time on January 18. KMA leadership and staff will monitor the deliberations of this group very closely and will provide updates as news develops.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Bell

John F. Jones, MD — AN
3600 W Cumberland, Middlesboro
40965
1983, East Carolina

Boyle

Timothy D. Adkins, MD — S
222 S 3rd St, Danville 40422
1990, U of Kentucky

Caldwell

Jacques Frenette, MD — GP
105 Cassidy Ave, Fredonia 42411
1975, U of Montreal

Davies

Brett C. Davis, MD — GE
2010 Old Cabin Rd, Owensboro 42310
1984, U of Arkansas

Fayette

George L. Cooper, MD — OPH
1760 Nicholasville Rd Ste 502,
Lexington 40503
1991, Albany

Fernando DeCastro, MD — D
807 S Limestone St, Lexington 40508
1989, U of Missouri

Ray F. Garman, MD — IM
100 Trade St, Lexington 40510
1961, George Washington

Roderick A. Gex, MD — AN
3320 Bates Creek Rd Ste 204,
Lexington 40502
1988, Tulane

James C. Owen, MD — FP
330 Romany Rd, Lexington 40502
1976, U of Kentucky

Dinesh Ranjan, MD — S
196 Ashley Woods Rd, Lexington
40509
1980, Rajendra, India

Franklin

Mark D. Hughes, MD — IM
1021 Aderly Ln, Frankfort 40601
1990, U of Louisville

Paul R. Robinson, MD — FP
107 Diagnostic Dr, Frankfort 40601
1987, U of Oklahoma

Graves

Thomas M. Mahany, MD, PhD — S
1319 Linwood Dr, Mayfield 42066
1984, Virginia

Hopkins

Jesus O. Agomaa, MD — IM
200 Clinic Dr, Madisonville 42431
1989, U of Santo Tomas, Philippines

Maria L. Lopez, MD — PD
265 White Oak Ln, Madisonville 42431
1991, U Central del Caribe,
Puerto Rico

Benito G. Pataroque, MD — IM
200 Clinic Dr, Madisonville 42431
1989, U of Santo Tomas, Philippines

Ronnie G. Tan, MD — IM
200 Clinic Dr, Madisonville 42431
1989, U of Santo Tomas, Philippines

Michael Tan, MD — IM
200 Clinic Dr, Madisonville 42431
1989, U of Santo Tomas, Philippines

Hardin

- Joseph G. Fine, MD** — S
1700 Ring Rd, Elizabethtown 42701
1982, U of Michigan
- Suresh B. Kodali, MD** — P
906 Woodland Dr Ste 202,
Elizabethtown 42701
1978, Rangaraya, India

Jefferson

- Jesse E. Adams III, MD** — C
225 Abraham Flexner Way Ste 305,
Louisville 40202
1987, Bowman Gray
- Massoud Ansari-Leesar, MD** — C
9991 Willowbrook Cir, Louisville
40223
1980, Mashad, Iran
- Fred W. Caudill III, MD** — P
4010 Dupont Cir Ste 581, Louisville
40207
1987, U of Louisville
- Luke J. Curtsinger, MD** — PS
4001 Dutchmans Ln Ste 3-E, Louisville
40207
1985, U of Louisville
- W. Andre Duff, MD** — IM
2606 Kings Hwy, Louisville 40205
1990, U of Louisville
- Carmine J. Esposito, DMD** — DENT
UL School Of Dentistry, Louisville
40292
1977, U of Louisville
- Ravi S. Gill, MD** — IM
2400 Mellwood Ave Apt 304,
Louisville 40206
1988, Christian, India
- Jill B. Green, MD** — OBG
4001 Dutchmans Ln Ste 5-C, Louisville
40207
1991, U of Louisville
- Robert Hilgers, MD** — OBG
529 S Jackson St, Louisville 40201
1961, Minneapolis
- Sven T. Jonsson, MD** — FP
312 S Lyndon Ln, Louisville 40222
1985, U of Cape Town, Africa
- Curtis A. Jordan, MD** — OPH
1919 State St Ste 140, New Albany
47160
1984, Indiana
- William B. King, MD** — EM
1021 Anchorage Woods Cir, Louisville
40223

- 1989, U of Louisville
- Ronald M. Kline, MD** — PD
4018 Brownlee Rd, Louisville 40207
1985, U of California
- Kevin T. McGann, MD** — EM
217 E Chestnut St, Louisville 40202
1973, U of Louisville
- Craig S. Rock, MD** — PS
4001 Dutchmans Ln Ste 3-C, Louisville
40257
1986, CMDNJ, Rutgers
- Jim F. Sharp, MD** — FP
1108 Greenock Ct, Louisville 40243
1974, U of Tennessee
- Janice E. Sullivan, MD** — PD
2908 Murray Hill Pike, Louisville
40242-2930
1988, U of Minnesota

Kenton

- Steven E. Neus, MD** — FP
13473 Kenton Station Rd, Morning
View 41063
1991, U of Kentucky

Knox

- Ashutosh S. Lohe, MD** — IM
PO Box 346, Flat Lick 40935
1986, G.S. Medical, India

Mason

- John T. Meredith, MD** — PTH
1096 Ashwood Dr, Maysville 41056
1975, Washington U
- Laura L. Shower, MD** — OBG
991 Medical Park Dr Ste 309, Maysville
41056
1989, Vanderbilt

Meade

- Louisa M. Tolentino, MD** — FP
502 River Ridge Medical Pl,
Brandenburg 40108
1990, U of Santo Tomas, Philippines

Montgomery

- Veronica A. Vasicek, MD** — ORS
1 Sterling Ave, Mount Sterling 40353
1990, Quillen-Dishner

Pike

- Yasser A. Saloum, MD** — IM
59 Thacker Rd Apt 4, Pikeville 41501
1990, Damascus U, Syria

Taylor

- Lora Sztendera, MD** — FP
59 Joe Kerr Rd, Campbellsville 42718
1988, U of Louisville

Whitley

- Abdul H. Munis, MD** — IM
412 Sycamore St, Williamsburg 40769
1984, Dow, Pakistan

In-Training**Fayette**

- Jenkins L. Clarkson,** — OBG
MD, PhD
- Lynn N. Lameier, MD** — OBG
- Steven E. Morton, MD** — IM

Hopkins

- Jeremy L. Bradley, MD** — FP
- Darby Cole, MD** — FP
- John R. Ewing, MD** — FP
- Kenneth L. Holder, MD** — FP
- Brian T. O'Donoghue, MD** — FP
- Kristy L. Wells, MD** — FP
- Lathon D. Worthington, MD** — FP

Jefferson

- Mark Alfonso, MD** — R
- Jose S. Bada, MD** — FP
- Robin B. Bideau, MD** — PTH
- Michael H. Edwards, MD** — RHU
- David M. Faber, MD** — S
- Nina French, MD** — IM
- James T. Miles, MD** — EM
- Timothy G. Price, MD** — EM
- Barbara Jo Schrodtt, MD** — PD

Northern Kentucky

- Richard L. Harover, MD** — FP

Impaired Physicians Program
9000 Wessex Place, Suite 305
Louisville, KY 40222

New Phone Number
502/425-7761

New Fax Number
502/425-6871

DEATHS**Mehdi Zagar, MD
Highland Heights
1942-1995**

Mehdi Zagar, MD, an obstetrician/gynecologist, died November 5, 1995. Dr Zagar graduated from Shiraz University Medical School in 1968 and was an active member of KMA.

**Waren Vinson Pierce, MD
Covington
1901-1995**

Waren Vinson Pierce, MD, a retired urologist, died November 23, 1995. A 1934 graduate of the University of Louisville School of Medicine, Dr Pierce was a life member of KMA.

**Ellis Duncan, Jr, MD
Louisville
1908-1995**

Ellis Duncan, Jr, MD, a retired general surgeon, died November 26, 1995. Dr Duncan was a 1936 graduate of the University of Louisville School of Medicine and was a life member of KMA.

**Phatick K. Mukherji, MD
Louisville
1924-1995**

Phatick K. Mukherji, MD, a pediatrician, died December 8, 1995. A 1946 graduate of R. G. Kar Medical School, India, Dr Mukherji was an active member of KMA.

**J. Campbell Cantrill, MD
Georgetown
1923-1995**

J. Campbell Cantrill, MD, a retired family practitioner, died December 13, 1995. Dr Cantrill was a 1950 graduate of the University of Virginia School of Medicine and a life member of KMA. His service to KMA included Chair of the Committee on State Legislative Activities, 9th District Trustee during

1970-73, Vice President, and as a member of the KMA Judicial Council for 18 years.

**Millard R. Shaw, MD
Henderson
1920-1995**

Millard R. Shaw, MD, a retired internist, died December 17, 1995. A 1944 graduate of the University of Utah College of Medicine, Dr Shaw was a life member of KMA.

**Henry J. Beilman, MD
Louisville
1917-1995**

Henry J. Beilman, MD, a retired family practitioner, died December 20, 1995. Dr Beilman was a 1949 graduate of the University of Louisville School of Medicine and a life member of KMA.

**George E. Ainsworth, Sr, MD
Madisonville
1925-1996**

George E. Ainsworth, Sr, MD, a retired orthopedic surgeon, died January 1, 1996. A 1948 graduate of Georgetown University School of Medicine, Dr Ainsworth was a life member of KMA.

**Edwin H. West, MD
Louisville
1913-1996**

Edwin H. West, MD, a retired public health physician, died January 3, 1996. Dr West graduated from Tulane University School of Medicine in 1937 and was a life member of KMA.

**R. Rodes Burnam, MD
Louisville
1919-1996**

R. Rodes Burnam, MD, a retired general surgeon, died January 7, 1996. A 1951 graduate of the University of Louisville School of Medicine, Dr Burnam was a life member of KMA.

**Thomas R. Watson, MD
Louisville
1935-1996**

Thomas R. Watson, MD, an obstetrician/gynecologist, died January 15, 1996. Dr Watson graduated from the University of Louisville School of Medicine in 1961. He was a former vice president of the Kentucky Medical Association and for eight years served on the State Health Facilities and Health Services Board. Dr Watson was also a member of U of L's Board of overseers and was a clinical associate professor at the medical school.

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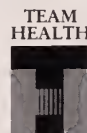
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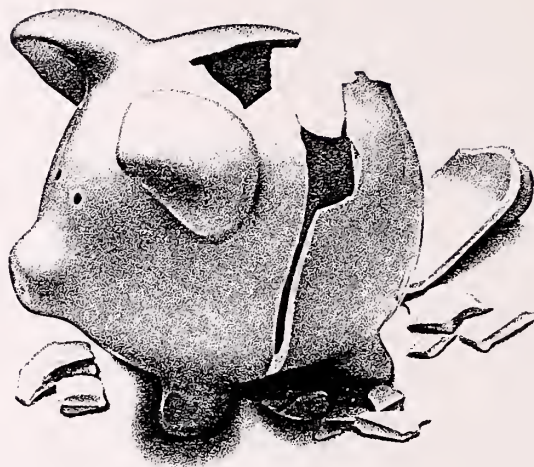
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VOLUME 94, NUMBER 4

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| | | |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|------------|
| COVER STORY | Special Called Session — KMA House of Delegates | 135 |
| | Digest of Proceedings | 138 |
| | Roll Call | 140 |
| SCIENTIFIC | Progressive Massive Fibrosis in a Zinc Miner <i>Betty W. Joyce, MD; Ernesto Mejia, MD; Michael Puruckherr, MD; Thomas M. Roy, MD</i> | 144 |
| | The Polymerase Chain Reaction: A Revolutionary New Procedure for the Laboratory Diagnosis of Infectious Disease <i>George E. Buck, PhD</i> | 148 |
| SPECIAL ARTICLE | Noncompetition Agreements in Kentucky Health Care <i>Scott W. Dolson</i> | 154 |
| EDITORIAL | The Patient's Last Advocate <i>Jaroslav P. Stulc, MD</i> | 161 |
| ASSOCIATION | <i>Monitoring Medicine</i> | 135 |
| | KMA Board of Trustees Special Called Meetings | 164 |
| | News | 164 |
| DEPARTMENTS | President's Page | 133 |
| | Advertisers' Guide | 170 |
| | Alliance Page | 162 |
| | Classifieds | 169 |
| | Information for Authors | 158 |
| | Letters to the Editor | 160 |



COVER: Delegates at the KMA Special Session of the House of Delegates heard brief comments from four KMA members currently serving in state government. Pictured at the podium are, clockwise from the top left photo, State Representative Bab DeWeese, MD; Lt Governor Steve Henry, MD; Senator James Crose, MD; and Representative Ernie Fletcher, MD. In the bottom left photo, President Danny M. Clark, MD, is pictured addressing the Delegates. KMA's State Legislative Chair, Wally O. Mantgamery, MD, is in the center photo. Several of KMA's Board members are also included in these photos.
Design and artwork by Lee Wade of Louisville.

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Managed Care

As this column is written, the General Assembly is still in session and only one bill relating to managed care has received much attention at this point. It appears that bills allowing 48 hours stay for normal, vaginal delivery and 96 hours following cesarean section will pass easily. It is difficult for legislators to oppose motherhood — but this is only the tip of the iceberg. This bill only scratches the surface of the inequities and downright chicanery of managed care folks to enhance their portfolios at the expense and pain of patients.

Arbitrary decisions regarding length of stay are being made every day by faceless entities at the other end of a phone line who never see the patient. Unfortunately, this is not limited to obstetrical services. While it is difficult for physicians to accept legislators dictating length of stay for patients, or any other parameters for medical care, it appears that our patients have no other recourse. We know that medical decisions should be made by the attending physician and the patient. However, this point needs to be made over and over to our patients, their employers, and legislators.

The art of medicine still prevails and no list of parameters or pages and pages of guidelines can adequately determine without careful bedside evaluation when a patient is ready to be discharged.

Despite managed care companies' profit margin and bottom line approach to medical care, it is our duty to resist them when they threaten quality care. When CEOs of the seven largest managed care companies in the nation receive compensation ranging between \$2.3 and \$14.2 million a year for their management skills, we know that patient care suffers because this money should be available to provide care for people rather than enriching

those CEOs. A prominent national publication once labeled those folks and their companies the "money machines of America."

When managed care companies place economic restraints on your ability to care for the patient, you must do everything in your power to assure the patient receives quality care despite third party interference. The "gag rule" imposed by some companies should be considered unethical and immoral. If our patients are best cared for by someone out of the network, we have an obligation to tell them of this. During the session, the KMA hopes to introduce legislation to address the "gag rule" and achieve some results in this area. In addition, we are preparing a "Patient Protection" bill based on AMA's model legislation. Patient protection and "point of service" options included in the model bill may provide some relief to our patients and the professions. In addition, Congress is also beginning to react to managed care's strong arm tactics and patient abuse.

Above all, be wary of the liabilities managed care may leave you with. Be sure that any contracts you sign are reviewed by an attorney well versed in health care law. Many contracts leave the physician responsible for decisions that they have no voice in making, particularly length of stay and the provision of treatment. If your patient's lab work is referred to a laboratory chosen by the managed care company, who attests to the quality of lab work that is done there? One company asked me to send Pap smears to a laboratory I have never heard of which is located in another state. How is it possible to evaluate their quality of work? If the quality is deficient — guess who bears part of the blame — and the liability. You can rest assured the managed care folks will deny responsibility.



Danny M. Clark, MD

"The art of medicine still prevails and no list of parameters or pages and pages of guidelines can adequately determine without careful bedside evaluation when a patient is ready to be discharged."

Obviously, there are more questions about managed care than answers. We are the only part of the equation that truly has the best interest of our patients at heart. We must make every effort to do whatever it takes to protect our patients and to insure that the bottom line is quality of care, not how much money the managed care company made that year.

Danny M. Clark, MD
KMA President

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KMA House of Delegates Special Session

Not since April 15, 1981, has a Special Session of The Kentucky Medical Association House of Delegates been called, but that was the order of business on Sunday, March 3, 1996, when a quorum of Delegates convened, at the request of the Northern Kentucky Medical Society. The call of this Special Session was limited to discussion of KMA policy relating to repeal of the physician component of the provider tax, adequate funding for Kentucky's Medicaid program, and the amendment/repeal of certain onerous portions of House Bill 250.

Preceding the nearly 3-hour meeting, Delegates heard brief comments from four KMA members currently serving in state government — Lt Governor Steve Henry, MD; Senator James Crase, MD; and Representatives Bob M. DeWeese, MD, and Ernie Fletcher, MD. Comments and questions from the floor concerning key issues were addressed by this group, prior to their departure so the House of Delegates meeting could officially convene.

A report on the action taken at this Special Session and a full Roll Call of Delegate attendance appears in the House of Delegates section, following Monitoring Medicine.

Stay Involved — We Must Be Heard

KMA is continuously monitoring developments in the legislature that affect our members and their patients. Even though the 1996 Legislative Session has adjourned, we hope that you will continue to help us address your concerns by working with the Legislative Committee and KMA's leadership on issues of importance to you and your patients.

Remember, your involvement in the legislative process ensures that your patients' and the profession's voices are heard. Please help us shape the health care system in Kentucky. *KMA*

Please turn the page for pictorial highlights of the Special Session.

MONITORING MEDICINE

BEING HEARD

Right—Alan T. Mang, MD, a Marehead surgeon.

Far Right—J. Gregory Caaper, MD, a Cynthiana family practitioner and KMA Alternate Delegate to AMA speaks, as Emery A. Wilson, MD, a Lexington reproductive endocrinologist and UK Medical School Dean, awaits his turn.

Below—There were few empty seats as KMA Delegates convened for this special called session.



Above—Arthur K. Rivard, Jr., a Danville ophthalmologist.

Right—Philip S. Becker, MD, a Crestview Hills neurologist is at the microphone and Richard E. Park, MD, a Cavington anesthesiologist is in line to speak.



MONITORING MEDICINE



Above, LtaR—William C. Harrison, MD, an Owensboro radiologist. Larry S. Fields, MD, an Ashland family practitioner; David T. Allen, MD, a Louisville preventive medicine specialist; and Dr Park.

Center, LtaR—Paul W. Craig, MD, an Ashland internist; G. Irene Minar, MD, a Berea family practitioner and KMA 11th District Trustee; Thomas E. Bunnell, MD, an Erlanger internist.

Below, LtaR—William B. Mannig, MD, an Edgewood urologist and KMA Alternate Delegate to the AMA, is followed by Dr Craig and Michael R. Kirkwaad, MD, an Edgewood ob/gyn.



***Digest of Proceedings of a Special Session of the House of Delegates**

**C. Kenneth Peters, MD, Jeffersontown
Speaker of the House
Presiding**

C Kenneth Peters, MD, Speaker of the KMA House of Delegates, called the Special Session of the House of Delegates to order at 2:14 pm, Sunday, March 3, 1996, at the Hyatt Regency Hotel, Louisville, Kentucky.

Following the invocation given by Linda H. Gleis, MD, Louisville, the Speaker called on William P. VonderHaar, MD, Louisville, to make announcements. He then called on J. Michael Moore, MD, Lexington, Chair of the Credentials Committee, who reported that a quorum was present.

Dr Peters introduced Danny M. Clark, MD, KMA President, who provided the Delegates with an overview of events leading up to the meeting. Following Dr Clark, the Speaker introduced Lt Governor Stephen L. Henry, MD; Senator James D. Crase, MD; Representative Bob M. DeWeese, MD; and Representative Ernest L. Fletcher, MD, who provided the Delegates with an up-to-date overview of legislative activities in Frankfort.

The House reviewed Resolution A, Special Session — KMA House of Delegates, introduced by Northern Kentucky Medical Society. It was the consensus of the House that Dr Peters be given editorial prerogative to delete the portions of Resolution A referring to the call of the Special Session. Donald J. Swikert, MD, Florence, moved to have each of the remaining Resolveds considered individually. The motion was seconded from the floor and carried.

Arthur K. Rivard, Jr, MD, Danville, recommended that the second Resolved be amended by adding "or phase out" after "repeal" in both instances; adding "at its current rate" after "collected"; and changing the word "rescind" to "adjust," as follows:

**Editorial Note: A tape recording was made of the special session of the House of Delegates, and any member who wishes to examine the transcript of these Proceedings may visit the Headquarters Office and listen to the recording.*

RESOLVED, the KMA shall adopt as policy that reasonable, legal, administrative and legislative efforts will be made by the KMA to ensure that the 1996 General Assembly, and the Governor of Kentucky, Mr Paul Patton, and the Executive Branch of this Administration know that the physicians of this state want immediate repeal or phase out of the provider tax on physicians and that such immediate repeal or phase out clearly states that the physician provider tax will no longer be able to be collected at its current rate after July 1, 1996, or a time certain that is the earliest time that the 1996 General Assembly can rescind adjust an existing tax; and be it further

Following considerable discussion, a motion was made, seconded, and carried to adopt the Resolved as amended.

A motion was then made and seconded to adopt Resolution A as amended. After considerable discussion, the question was called and the motion carried.

RESOLUTION A (Adopted as amended)

Special Session – KMA House of Delegates Northern Kentucky Medical Society, Inc

WHEREAS, the KMA House of Delegates at the 1994 Annual Meeting adopted the Board of Trustees Amended Resolution A, which resolved, in part, that "KMA develop and disseminate a legislative strategy to improve the likelihood that the 1996 Legislature will rescind the so-called provider tax, or 'sick' tax, as a method of funding the Medicaid Budget"; and

WHEREAS, the KMA House of Delegates at the 1995 Annual Meeting adopted Jefferson County Medical Society's Amended Resolution I, which resolved, in part, that "the KMA reaffirm its opposition to the provider tax; and be it

further resolved, that the KMA reaffirm its opposition to the provider tax; and be it further resolved, that the KMA maintain as a top legislative priority the repeal of the provider tax by the 1996 Kentucky General Assembly"; and

WHEREAS, the KMA House of Delegates at the 1995 Annual Meeting adopted Floyd County Medical Society's Resolution S, as amended, which resolved, in part, that the KMA actively promote a reasonable reimbursement rate for Medicaid providers; and be it further Resolved, that the KMA stands for adequate and broad-based state general funding for the Medicaid program; and

WHEREAS, the President of the KMA in an open letter to the physicians of Kentucky again reiterated that the *immediate* repeal of the provider tax remains a top priority of the KMA; and

WHEREAS, Governor Patton and his Administration are advocating a phase out of the provider tax on physicians over a three- or four-year period of time to make it easier to balance the budget and maintain the present Medicaid program; and

WHEREAS, the commonly accepted definition of immediate means "not separated in time, acting or happening at once, without delay, instant"; and

WHEREAS, members of the 1996 General Assembly claim to be confused about the position of the KMA concerning the KMA policy referable to repeal of the provider tax on physicians; now, therefore, be it

RESOLVED, that the Special Session of the House of Delegates affirm the current policy of the KMA as stated, in part, in the Adopted Amended Resolution 1, originally sponsored by the Jefferson County Medical Society, of the House of Delegates in 1995, which stated, in part, that "the KMA reaffirm its opposition to the provider tax; and be it further Resolved, that the KMA maintain as a top legislative priority the repeal of the provider tax by the 1996 Kentucky General Assembly"; and be it further

RESOLVED, that the Special Session of the House of Delegates shall consider the following Resolution:

RESOLVED, the KMA shall adopt as policy that reasonable, legal, administrative and legislative efforts will be made by the KMA to ensure that the 1996 General Assembly, and the Governor of Kentucky, Mr Paul Patton, and the Executive Branch of this Administration know that the physicians of this state want immediate repeal or phase out of the provider tax on physicians and that such immediate repeal or phase out clearly states that the physician provider tax will no longer be able to be collected at its current rate after July 1, 1996, or a time certain that is the earliest time that the 1996 General Assembly can adjust an existing tax; and be it further

RESOLVED, that this Special Session of the House of Delegates of the KMA affirm the present KMA policy concerning reasonable reimbursement rate for the Medicaid providers that is in part stated by the Adopted, Amended Resolution

S, originally introduced by the Floyd County Medical Society, 1995 House of Delegates Annual Meeting, that stated, in part, "Resolved, that the KMA actively promote a reasonable reimbursement rate for Medicaid providers."

The House considered Resolution B, Legislative Policy, introduced by the KMA Board of Trustees. A motion was made from the floor, seconded, and carried that Resolution B be adopted.

RESOLUTION B

Legislative Policy

KMA Board of Trustees

WHEREAS, the 1992 KMA House of Delegates adopted Resolution B which formulated and established the legislative policy of the KMA; and

WHEREAS, it is the desire of the Board that this position be reaffirmed and adopted by the 1996 Special Session of the KMA House of Delegates; now, therefore, be it

RESOLVED, that the KMA House of Delegates reaffirms its policy regarding coordination of state legislative activities which includes:

1. All state legislative proposals are to be coordinated by and channeled through the Committee on State Legislative Activities;
2. The composition, authority, and function of the Quick Action Committee are to be retained;
3. The composition, priority, manner, and time of introduction of state legislative proposals are to be left to the discretion of the Chairman of the Committee on State Legislative Activities and the Quick Action Committee; and be it further

RESOLVED, that the House of Delegates, recognizing the enormous task KMA faces as dramatic transformations are proposed in the health care delivery system which require immediate decisions, authorizes the Quick Action Committee, in consultation with the Executive Committee, when indicated, to set legislative policies determined to be in the best interest of the Association, and to represent the Association in all matters; and be it further

RESOLVED, that the President of KMA is authorized to call emergency meetings of the KMA Board of Trustees, as necessary, and special sessions of the House of Delegates in accordance with the Constitution and Bylaws, if appropriate; and be it further

RESOLVED, that the Chairman of the KMA Committee on State Legislative Activities shall keep the membership of KMA, the House of Delegates, and the Board of Trustees fully informed as to the progress of legislative deliberations and provide to the membership details of KMA's plans and recommendations on becoming involved.

There being no further business to come before the Delegates, Dr Peters adjourned the meeting at 4:20 PM.

ROLL CALL

1996 House of Delegates

Special Session

March 3, 1996

OFFICERS

| | |
|------------------------|---------------------------|
| Speaker | C. Kenneth Peters, MD |
| Vice Speaker | Jahn W. McClellan, Jr, MD |
| President | Danny M. Clark, MD |
| President-Elect | William H. Mitchell, MD |
| Vice-President | Danald R. Stephens, MD |
| Secretary-Treasurer | William P. VonderHaar, MD |
| AMA Delegate | Danald C. Barton, MD |
| AMA Delegate | Robert R. Gaadin, MD |
| AMA Delegate | Ardis D. Haven, MD |
| AMA Delegate | Wally O. Mantgomery, MD |
| AMA Delegate | Danald J. Swikert, MD |
| AMA Alternate Delegate | Baretta R. Casey, MD |
| AMA Alternate Delegate | J. Gregory Cooper, MD |
| AMA Alternate Delegate | Bab M. DeWeese, MD |
| AMA Alternate Delegate | William B. Mannig, MD |
| AMA Alternate Delegate | Preston P. Nunnelley, MD |

TRUSTEES

| | |
|---------------------|--------------------------|
| First District | Harry W. Carllass, MD |
| Secand District | Danald R. Neel, MD |
| Third District | C. R. Dadds, MD |
| Faurth District | Eugene H. Shively, MD |
| Fifth District | Joseph E. Kutz, MD |
| Sixth District | J. Michael Pulliam, MD |
| Seventh District | Ronald E. Walldridge, MD |
| Eighth District | Mark F. Pelstring, MD |
| Ninth District | J. Gregory Cooper, MD |
| Tenth District | Russell L. Travis, MD |
| Eleventh District | G. Irene Minar, MD |
| Twelfth District | Scott B. Scutchfield, MD |
| Thirteenth District | Kenneth R. Hauswald, MD |
| Faurteenth District | E. D. Roberts, MD |
| Fifteenth District | Paul R. Smith, MD |

ALTERNATE TRUSTEES

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| First District | Robert C. Hughes, MD |
| Secand District | Joseph H. Harpale, Jr, MD |
| Third District | Uday V. Dave, MD |
| Fourth District | Brian F. Wells, MD |
| Fifth District | Daniel W. Varga, MD |
| Sixth District | John T. Burch, II, MD |
| Seventh District | Jahn M. Patterson, MD |
| Eighth District | John D. Ammon, MD |
| Ninth District | Robert L. McKenney, MD |
| Tenth District | Andrew R. Pulito, MD |
| Eleventh District | Richard A. Stane, MD |
| Twelfth District | Danald E. Brawn, MD |
| Thirteenth District | Susan H. Prasher, MD |
| Faurteenth District | Baretta R. Casey |
| Fifteenth District | Rager A. Acasta, MD |

PAST PRESIDENTS

| | |
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| Past President | Robert R. Gaadin, MD |
| Past President | Ardis D. Haven, MD |
| Past President | William B. Mannig, MD |
| Past President | S. Randolph Scheen, MD |
| Past President | Preston P. Nunnelley, MD |

Special
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DELEGATES
FIRST DISTRICT

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| BALLARD..... | Martha C. Rabinsan, MD, Barlow |
| CALLOWAY..... | Robert C. Hughes, MD, Murray |
| | Rab T. Williams, MD, Murray |
| CARLISLE..... | |
| FULTON..... | Edward B. McWhirt, MD, Fulton |
| GRAVES..... | Charles E. Bea, MD, Mayfield |
| | Patricia S. Elliott, MD, Mayfield |
| HICKMAN..... | Bruce C. Smith, MD, Clinton |
| LIVINGSTON..... | Stephen Burkhart, MD, Salem |
| McCRACKEN..... | Harry W. Carllass, MD, Paducah |
| | Peter E. Lacken, MD, Paducah |
| | Charles B. Rass, MD, Paducah |
| | Carolyn S. Watsan, MD, Paducah |
| | Wally O. Mantgamery, MD, Paducah |
| MARSHALL..... | |

Special
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SECOND DISTRICT

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| DAVIESS..... | William Milnor, MD, Owensboro |
| | Robert Cautant, MD, Owensboro |
| | William Harrison, MD, Owensboro |
| | Wathen Medley, Jr, MD, Owensboro |
| | Danald R. Neel, MD, Owensboro |
| | Robert H. Schell, MD, Owensboro |
| | R. J. Phillips, Jr, MD, Owensboro |
| HANCOCK..... | |
| HENDERSON..... | Joseph H. Harpale, Jr, MD, Henderson |
| | Marcia L. Cave, MD, Henderson |
| | Marshall Hawell, III, MD, Henderson |
| MCLEAN..... | |
| OHIO..... | Eric A. Narsworthy, MD, Hartford |
| UNION..... | Wallas N. Bell, MD, Morganfield |
| WEBSTER..... | |

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THIRD DISTRICT

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| CALDWELL..... | |
| CHRISTIAN..... | James C. King, Jr, MD, Hopkinsville |
| CRITTENDEN..... | |
| HOPKINS..... | Uday V. Dave, MD, Madisanville |
| | C. R. Dadds, MD, Earlington |
| LYON..... | |
| MUHLBERG..... | James S. Brashear, MD, Central City |
| TODD..... | |
| TRIGG..... | |

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FOURTH DISTRICT

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| BRECKINRIDGE..... | |
| BULLITT..... | |
| GRAYSON..... | Arthur J. McLaughlin, II, MD, Leitchfield |
| GREEN..... | William L. Shuffett, MD, Greensburg |
| HARDIN..... | Arvil G. Catlett, MD, Hodgenville |
| | William C. Nash, MD, Elizabethtown |
| | Mahendra Patel, MD, Elizabethtown |
| | Jeffrey B. Richardson, MD, Elizabethtown |
| | David J. Zaeller, MD, Elizabethtown |
| | James W. Middleton, Jr, MD, Munfardville |
| HART..... | |
| LARUE..... | |
| MARION..... | Richard L. Litt, MD, Lebanon |
| MEADE..... | Raymond L. Mathis, DO, Brandenburg |
| NELSON..... | Lloyd A. Manchikes, MD, Bardstawn |
| TAYLOR..... | Eugene H. Shively, MD, Campbellsville |
| WASHINGTON..... | Brian F. Wells, MD, Springfield |

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FIFTH DISTRICT

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| JEFFERSON..... | Jannice O. Aaron, MD, Louisville | |
| | Edward C. Adler, MD, Louisville | |
| | David T. Allen, MD, Louisville | Present |
| | Kenneth C. Anderson, MD, Louisville | Present |
| | George R. Aranoff, MD, Louisville | Present |
| | Joseph C. Bonis, Jr, MD, Louisville | Present |
| | Susan M. Berberich, MD, Louisville | Present |
| | S. J. Bertalone, Jr, MD, Louisville | Present |
| | David H. Bizat, MD, Louisville | Present |
| | C. Matthew Brown, MD, Louisville | ..... |
| | Gregory L. Brawn, MD, Louisville | ..... |
| | Wm. C. Buschemeyer, Jr, MD, Louisville | ..... |
| | David E. Bybee, MD, Louisville | Present |
| | Donn R. Chatham, MD, Louisville | ..... |
| | William Cheadle, MD, Louisville | Present |
| | J. William Comer, MD, Louisville | Present |
| | Peter M. Conway, MD, Louisville | ..... |
| | Deborah L. Capeland, MD, Louisville | ..... |
| | Warren Cox, IV, MD, Louisville | Present |
| | Frederick Cressman, Jr, MD, Louisville | ..... |
| | John H. Doyle, MD, Louisville | Present |
| | Rudy J. Ellis, Jr, MD, Louisville | Present |
| | John M. Farmer, MD, Louisville | ..... |
| | Morjorie R. Fitzgerald, MD, Louisville | Present |
| | Gary L. Fuchs, MD, Louisville | ..... |
| | Hoyt Gardner, MD, Louisville | Present |
| | Darius Ghazi, MD, Louisville | ..... |
| | Carolyn B. Gleason, MD, Louisville | Present |
| | Linda H. Gleis, MD, Louisville | Present |
| | Leonard A. Goddy, MD, Louisville | ..... |
| | Lawrence G. Goldberg, MD, Louisville | ..... |
| | Richard A. Gould, MD, Louisville | ..... |
| | Monuel Grimaldi, MD, Louisville | ..... |
| | Kathleen C. Harter, MD, Louisville | ..... |
| | B. Thamos Horter, Jr, MD, Louisville | Present |
| | Anna K. Huang, MD, Louisville | ..... |
| | Jahn G. Hubbard, MD, Louisville | ..... |
| | Wolter I. Hume, Jr, MD, Louisville | Present |
| | Barbara Sue Isaacs, MD, Louisville | ..... |
| | Sheri A. Kolbfeisch, MD, Louisville | ..... |
| | Jahn M. Kariba, MD, Louisville | Present |
| | Danald R. Kmetz, MD, Louisville | ..... |
| | Joseph E. Kutz, MD, Louisville | Present |
| | Julie Lee, MD, Louisville | Present |
| | Michael T. Macforlone, MD, Louisville | ..... |
| | James E. McKiernan, Jr, MD, Louisville | ..... |
| | Frank B. Miller, MD, Louisville | Present |
| | Catherine Newton, MD, Louisville | Present |
| | Thomas O'Daniel, MD, Louisville | Present |
| | Steve J. Raible, MD, Louisville | ..... |
| | James E. Redman, MD, Louisville | Present |
| | K. Thomas Reichard, MD, Louisville | ..... |
| | Bartan Reutlinger, MD, Louisville | ..... |
| | Koilosh C. Sabharwal, MD, Louisville | Present |
| | George Rondolph Schrodt, MD, Louisville | Present |
| | George R. Schrodt, Jr, MD, Louisville | ..... |
| | Edward L. Scafield, MD, Louisville | Present |
| | Lynn T. Siman, MD, Louisville | ..... |
| | William C. Templeton, III, MD, Louisville | ..... |
| | Alfred L. Thompson, MD, Louisville | Present |
| | Brenda I. Tawnes, MD, Louisville | ..... |
| | Stuart Urbach, MD, Louisville | Present |
| | Daniel W. Varga, MD, Louisville | Present |
| | Gary C. Vitale, MD, Louisville | Present |
| | Henry J. Walter, MD, Louisville | ..... |
| | Norton G. Waterman, MD, Louisville | ..... |
| | Dovid R. Watkins, MD, Louisville | ..... |
| | Somuel D. Weakley, MD, Louisville | ..... |
| | James Anthony Wright, MD, Louisville | ..... |
| | Janet Wygol, MD, Louisville | ..... |
| | C. Milton Young, III, MD, Louisville | Present |
| | George H. Zenger, MD, Louisville | Present |

SIXTH DISTRICT

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| ADAIR..... | Richard Lenaghan, MD, Columbia | Present |
| ALLEN..... | Jahn M. Hall, MD, Scattsville | |
| BARREN..... | Warren J. Eisenstein, MD, Glasgow | Present |
| | Melissa Walton-Shirley, MD, Glasgow | ..... |
| BUTLER..... | Richard T. Wan, MD, Margantown | ..... |
| CUMBERLAND..... | Joseph D. Skipwarth, MD, Burkesville | ..... |
| EDMONSON..... | Omkar N. Bhatt, MD, Brownsville | ..... |
| LOGAN..... | ..... | ..... |
| METCALFE..... | Lawrence P. Emberton, MD, Edmantan | ..... |
| MONROE..... | James E. Carter, MD, Tamppkinsville | ..... |
| SIMPSON..... | Michael Pulliam, MD, Franklin | ..... |
| WARREN..... | Robert J. Emslie, MD, Bowling Green | |
| | Timothy K. Hulse, MD, Bowling Green | Present |

SEVENTH DISTRICT

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|---------------|--------------------------------------|---------|
| ANDERSON..... | Kenneth E. Hines, MD, Lawrenceburg | |
| CARROLL..... | Frank Frast Palmer, MD, Carralltan | Present |
| FRANKLIN..... | Willis P. McKee, Jr, MD, Frankfort | ..... |
| | John M. Patterson, MD, Frankfort | Present |
| | William F. Threlkeld, MD, Frankfort | ..... |
| | Benjamin Kutnicki, MD, Warsaw | Present |
| GALLATIN..... | ..... | ..... |
| GRANT..... | ..... | ..... |
| HENRY..... | James R. Smith, MD, Shelbyville | ..... |
| OLDHAM..... | Harold F. Funke, MD, Crestwood | ..... |
| OWEN..... | ..... | ..... |
| SHELBY..... | Ranald E. Woldridge, MD, Shelbyville | Present |
| SPENCER..... | Thomas C. Crain, MD, Taylarsville | Present |
| TRIMBLE..... | | |

EIGHTH DISTRICT

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| BOONE..... | Robert L. Baker, Jr, MD, Crescent Springs | Present |
| CAMPBELL..... | Scott Becker, MD | Present |
| | John P. Eldridge, MD, Crescent Springs | Present |
| | Steven M. Waadruff, MD, Florence | Present |
| KENTON..... | Gordon W. Air, MD, Crestview Hills | Present |
| | Elbert D. Baldridge, Jr, MD, Cavington | Present |
| | Thomas E. Bunnell, MD, Erlanger | Present |
| | James P. Farrell, MD, Crestview Hills | Present |
| | Paul R. Guenther, MD, Crestview Hills | Present |
| | Michael R. Kirkwood, MD, Covington | Present |
| | Rass McHenry, MD, Covington | Present |
| | George E. Miller, MD, Crescent Springs | Present |
| | Theodore H. Miller, MD, Edgewood | Present |
| | Neol J. Moser, MD, Burlington | Present |
| | Richard E. Pork, MD, Covington | Present |
| | Mork K. Pelstring, MD, Cavington | Present |
| | Richard Rice, MD, Edgewood | Present |

NINTH DISTRICT

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| BATH..... | | |
| BOURBON..... | Emmett Lee Tate, MD, Paris | |
| BRACKEN..... | | |
| FLEMING..... | | |
| HARRISON..... | J. Gregory Cooper, MD, Cynthiona | Present |
| | Danald R. Stephens, MD, Cynthiana | Present |
| MASON..... | ..... | ..... |
| NICHOLAS..... | ..... | ..... |
| PENDLETON..... | Robert L. McKenney, MD, Falmouth | Present |
| ROBERTSON..... | | |
| SCOTT..... | Jahn M. Bennett, MD, Geargetawn | |

TENTH DISTRICT

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| FAYETTE..... | James W. Baker, MD, Lexington | Present |
| | James R. Beon, MD, Lexington | |
| | David J. Bensemo, MD, Lexington | |
| | John V. Bards, MD, Lexington | |
| | Terry Dovid Clark, MD, Lexington | Present |

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| Jahn W. Collins, MD, Lexington | |
| W. Lisle Dalton, MD, Lexington | |
| Elvis S. Donaldson, Jr, MD, Lexington | |
| Ernest L. Fletcher, MD, Lexington | ..... |
| Carol L. Fowler, MD, Lexington | ..... |
| Jahn M. Fax, MD, Lexington | ..... |
| Bill H. Harris, MD, Lexington | ..... |
| Raleigh O. Janes, MD, Lexington | ..... |
| Magdalene B. Karan, MD, Lexington | ..... |
| Dennis B. Kelly, MD, Lexington | ..... |
| Daniel E. Kenady, Sr, MD, Lexington | ..... |
| Jahn M. Moore, MD, Lexington | ..... |
| William N. Offutt, IV, MD, Lexington | ..... |
| Charles L. Papp, MD, Lexington | ..... |
| Barbara A. Phillips, MD, Lexington | ..... |
| Andrew R. Pulita, MD, Lexington | ..... |
| Glenn R. Shearer, MD, Lexington | ..... |
| Thomas K. Slabaugh, MD, Lexington | ..... |
| David B. Stevens, MD, Lexington | ..... |
| Russell L. Travis, MD, Lexington | ..... |
| Jahn Robert White, MD, Lexington | ..... |
| Emery A. Wilson, MD, Lexington | ..... |
| T. Allen Woodward, MD, Lexington | |
| JESSAMINE..... | |
| WOODFORD..... | |
| C. Dole Goodin, MD, Versailles | |

ELEVENTH DISTRICT

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| CLARK..... | |
| ESTILL..... | |
| JACKSON..... | |
| LEE..... | |
| MADISON..... | |
| MENIFEE..... | |
| MONTGOMERY..... | |
| OWSLEY..... | |
| POWELL..... | |
| WOLFE..... | |
| Jahn A. Patterson, MD, Irvine | ..... |
| James B. Noble, MD, Beattyville | ..... |
| Jerry Krumpleman, MD, Richmand | ..... |
| G. Irene Minar, MD, Berea | ..... |
| Richard A. Hall, MD, Maunt Sterling | |
| Charles G. Nass, MD, Stanton | |
| Wallace L. Past, Jr, MD, Camptan | |

TWELFTH DISTRICT

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| BOYLE..... | |
| CASEY..... | |
| CLINTON..... | |
| GARRARD..... | |
| LINCOLN..... | |
| McCREARY..... | |
| MERCER..... | |
| PULASKI..... | |
| ROCKCASTLE..... | |
| Brian E. Ellis, MD, Danville | ..... |
| David C. Liebschutz, MD, Danville | ..... |
| Arthur K. Rivard, MD, Danville | ..... |
| Lewis E. Wesley, MD, Liberty | ..... |
| Michael Lee Cummings, MD, Albany | ..... |
| Paul J. Sides, MD, Lancaster | ..... |
| C. Glen Click, MD, Stanford | ..... |
| George W. Noe, MD, Harrodsburg | ..... |
| Danald E. Brown, MD, Somerset | ..... |
| Khalid Iqbal, MD, Somerset | ..... |
| Billy Joe Parson, MD, Somerset | |
| Joseph G. Weigel, MD, Somerset | |
| William D. Dooley, MD, Maunt Vernan | |

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| RUSSELL..... | H. Michael Oghia, MD, Russell Springs | |
| WAYNE..... | Edward Joseph, MD, Manticella | Present |

THIRTEENTH DISTRICT

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| BOYD..... | Paul W. Craig, II, MD, Ashland | Present |
| | Maurice J. Oakley, MD, Ashland | |
| | Jahn R. Potter, MD, Ashland | Present |
| | Suson Hess Prasher, MD, Ashland | ..... |
| | Charles T. Watson, MD, Ashland | ..... |
| | Dante R. Oreta, MD, Graysan | ..... |
| CARTER..... |  | ..... |
| ELLIOTT..... |  | ..... |
| GREENUP..... | Larry S. Fields, MD, Ashland | Present |
| | Laurent B. Tigas, MD, Russell | ..... |
| LAWRENCE..... | Michael Pravetz, MD, Louiso | Present |
| LEWIS..... |  | ..... |
| MORGAN..... | George R. Bellamy, MD, West Liberty | |
| ROWAN..... | Alan T. Mang, MD, Marehead | Present |


FOURTEENTH DISTRICT

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| BREATHITT..... | | |
| FLOYD..... | Clarita Valdez-Vicher, MD, McDowell | Present |
| | Gangadhar L. Maddiwar, MD, Martin | Present |
| | Rizaliwa Lavarra, MD, Paintsville | Present |
| JOHNSON..... |  | ..... |
| KNOTT..... |  | ..... |
| LETCHER..... |  | ..... |
| MAGOFFIN..... | Franklen K. Belhasen, MD, Paintsville | Present |
| MARTIN..... | Raymond Wells, MD, Inez | ..... |
| PERRY..... | Gilray Lane Daley, MD, Hazard | ..... |
| | David Krasnapolsky, MD, Hazord | ..... |
| PIKE..... | Baretta R. Casey, MD, Pikeville | ..... |
| | Lela C. Maynard, MD, Pikeville | Present |
| | E. D. Roberts, MD, Pikeville | Present |

FIFTEENTH DISTRICT

| | | |
|-------------------------------------------|---------------------------------------|---------|
| BELL..... | Meredith J. Evans, MD, Middlesbara | Present |
| | Charles C. Moore, Jr, MD, Middlesbara | ..... |
| CLAY..... | William E. Becknell, MD, Manchester | ..... |
| HARLAN..... | F. Andrew Marfesis, MD, Harlan | ..... |
| | Mila H. Schasser, MD, Benham | ..... |
| KNOX..... | Rogelio A. Acasta, MD, Barbaurville | ..... |
| LAUREL..... | David W. Douglas, MD, London | ..... |
| LESLIE..... | Ray Varghese, MD, Hyden | ..... |
| WHITLEY..... | Danald C. Barton, MD, Corbin | Present |
| KMA Hospital Medical Staff Section |  | ..... |
| William D. Pratt, MD, London |  | ..... |
| KMA Resident Physicians Section |  | ..... |
| Judy M. Linger, MD, Georgetown |  | ..... |
| KMA Student Section |  | ..... |
| Jahn Bruner, Lexington |  | ..... |
| Matt McDonald, Louisville |  | ..... |

The information in the roll call was taken from the attendance record cards signed by the delegates prior to the Special Session of the House, March 3.



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Progressive Massive Fibrosis in a Zinc Miner

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The diagnosis of progressive massive fibrosis (PMF) is traditionally associated with exposure to coal dust. Since the legislation of better control of mine dust, the incidence of PMF has declined significantly. Clinicians who are not regularly involved in the medical care of coal workers may have limited knowledge of this incapacitating problem. Physicians are reminded that PMF is a complex process that can occur after exposure to mixed respirable particles other than coal dust.

The occurrence of pulmonary opacities greater than 1-3 cm as a complication of occupational exposure to mineral dust is termed progressive massive fibrosis (PMF). The diagnosis is most often suggested by the radiographic presence of bilateral, asymmetric opacities involving the middle-upper and posterior lung fields of patients with a history of mining coal or exposure to respirable silicates.¹

The development of mineral dust-associated mass lesions typically occurs long after the patient has left the environment that predisposed to the prolonged inhalation of particulates. This feature is implied by the descriptive adjective "progressive."

We present a patient who worked for 35 years mining zinc. Because zinc is not traditionally associated with lung disease, the possibility of PMF was initially overlooked in favor of bilateral upper lobe pneumonia. We review the complex etiology of PMF and emphasize how the latency of PMF requires a detailed history of a worker's job description.

Case Report

A 69-year-old miner was transferred to the Veterans Administration Medical Center for additional evaluation of persistent bilateral upper lobe lesions. He had been hospitalized for 30 days prior to transfer and had been treated with intravenous antibiotics. He had received supportive measures for dyspnea at rest, nonproductive

cough, malaise, and weakness. Continuous oxygen at 1 LPM by nasal cannula was required to keep his PAO_2 above 60 torr.

The patient had quit cigarette smoking 13 years earlier after a total consumption equal to 80 pack-years. He worked as a truck driver for a grocery store until age 27 when he switched to working in a zinc mine. He retired after 35 years because the mine closed.

His vital signs were unremarkable except for a respiratory rate of 20 breaths per minute. Breath sounds were diminished in both upper lobes. End-inspiratory crackles were present bilaterally. No wheezing was present. Cardiac examination was notable for a pronounced pulmonic closure sound and a widened S2. There was no evidence of right heart failure nor clubbing of the digits. The remainder of the patient's examination was normal.

Induced sputa were nondiagnostic. CBC with differential as well as blood chemistries were unremarkable. Intermediate strength PPD was not reactive. A mumps skin test was reactive to 8 mm in duration. Urinalysis was nondiagnostic. Electrocardiogram was unremarkable. His chest radiograph showed bilateral upper lobe densities (Fig 1). The patient's pulmonary functions were consistent with a severe combined ventilatory defect with a significant decrease in his DLCO.

Bronchoscopy was performed before the patient was transferred. Bronchial washings, brushings, and transbronchial biopsies were obtained from the right upper lobe. The microbiologic and histologic examinations of this material were nondiagnostic. An open lung biopsy had been requested.

The patient's participation in zinc mining was not given much attention after the referring physician had determined that zinc is not a cause of pneumoconiosis. A more detailed occupational history was obtained. The patient had worked underground as a "pattern man." His job was to dynamite sandstone and limestone to produce rock samples that were removed from the

mine and later crushed to harvest a low yield of zinc. He had never worn a protective respirator during his employment.

A chest film from 10 years earlier was obtained from his private physician (Fig 2). This radiograph shows evidence of grade 2/3 silicosis. In this context, the diagnosis of progressive massive fibrosis could be made.

Discussion

Workers who labor in environments of respirable dust are likely to accumulate particulate matter in the lungs. Some individuals will develop a tissue reaction to this material. Pulmonary macrophages that are activated by mineral dusts can produce inflammatory and immune products within the alveolar structures that promote lung injury. Activated macrophages are capable of releasing cytokines as well as oxidants such as superoxide anion and hydroxy radicals. Through modulation of fibroblast proliferation, these oxidants lead to fibrosis with destruction of the parenchyma and the pulmonary vasculature.² Interestingly, the degree of parenchymal reaction



Fig 2 — Chest radiograph taken 10 years earlier, shortly after leaving the mine.



Fig 1 — Admission chest radiograph with bilateral upper lobe densities.

cannot be accurately predicted for an exposed individual.

Three major groups are identified using the standard chest radiograph and the regimented ILO interpretation scheme. Many exposed individuals will have normal chest films. Other individuals develop multiple small rounded or irregular opacities on the radiograph and are said to have simple pneumoconiosis. Those with radiographic opacities larger than 1 cm are classified as having progressive massive fibrosis (PMF).³

The distinction between simple pneumoconiosis and PMF is clinically relevant. Individuals with simple pneumoconiosis have a life expectancy and pulmonary function similar to those with normal radiographs. The presence of PMF predicts significant impairment of respiratory mechanics and premature death.⁴ For reasons that are unclear, once PMF has started it tends to increase rapidly despite removal from dust exposure.

The development of pneumoconiosis appears to be related to the mineral content of the dust and to the individual's cumulative dust burden. Still, only a minority of workers develop PMF despite dust concentrations that are similar to

Progressive Massive Fibrosis in a Zinc Miner

workers with simple pneumoconiosis. This observation indicates that dust exposure is not the only factor promoting fibrosis. Some individuals are obviously more susceptible than others to develop massive lesions.

The silica content of the mixed dust has been proposed as an important factor in development of PMF. The condition occurs more frequently in patients with classic silicosis than in coal workers. Likewise, massive fibrotic lesions occur more often in miners of anthracite coal (high silica content) than in miners of bituminous coal (low silica content).⁵

On the other hand, pathologic studies often find little or no silica in the lungs of coal workers with PMF.⁶ Inhaled silica-free carbon has been reported to cause PMF.⁷ Repeated hemorrhage into the lung has caused PMF.⁸ Finally, talc (magnesium silicate) delivered to the lungs intravenously has been associated with PMF.⁹

There is support for a direct dust dose-response relationship in PMF.¹⁰ Exceptions occur, however, and PMF has been reported in individuals after only brief coal dust exposure.¹¹ The decline in the incidence of PMF among British miners is often attributed to better dust control measures. Nevertheless, investigators point out that an estimate of the prevalence of PMF based on working miners underestimates the frequency of the condition by a factor of two and one-half.¹² Approximately two-thirds of individuals will first develop PMF after leaving the industry. Often, radiologic surveillance of miners stops when they leave the industry. Because individuals with PMF have premature demise, survival bias also influences the estimates of prevalence.

An early premise regarding the pathogenesis of PMF invoked the occurrence of a mycobacterial infection superimposed upon a pulmonary parenchyma whose defenses were impaired by the presence of dust. This theory was based on the observation that massive fibrotic lesions could be induced in the lungs of guinea pigs by exposure to a mixture of coal dust and attenuated mycobacteria.¹³ The lesions did not develop when the animals were exposed to either agent alone. Early autopsy studies performed on coal workers with PMF frequently found histologic and microbiologic evidence of tuberculosis.

This hypothesis is still mentioned in some texts despite the fact that there is little recent evidence to support a casual association of tuberculosis to PMF.¹⁴ Recent autopsy studies do not document the presence of tuberculosis as com-

monly as early studies despite better microbiologic techniques. There is no significant difference in *M tuberculosis* agglutinin titers between control subjects and miners with PMF.¹⁵ Antituberculous therapy does not influence the course of PMF.¹⁶

Another explanation for the apparent idiosyncratic reaction to respirable dust relies on the presence of heightened immunologic reactivity. This avenue of research was suggested by Caplan's observation of nodular masses on the chest radiographs of miners with rheumatoid arthritis.¹⁷ Early investigations confirmed a high prevalence of antinuclear antibody and rheumatoid factor in miners with evidence of PMF. More recent efforts to test this hypothesis have been conducted with more refined assays. Interestingly, a greater prevalence of autoantibodies is observed in subjects with pneumoconiosis than in control subjects.¹⁵ This observation may suggest that production of immunoglobulin reactive antibodies influences the development of simple pneumoconiosis.

Do these autoantibodies partially explain why miners with similar exposure to respirable dusts vary in their tendency to develop parenchymal fibrosis? Unfortunately, no serologic differences can be established between subjects with simple pneumoconiosis and those who develop progressive massive fibrosis.¹⁵ The autoantibodies may merely reflect the stimulus of dust exposure in the parenchyma and be of no pathologic significance in the causation of pneumoconiosis. In this regard, increased frequencies of anti-nuclear antibody and rheumatoid factor are also found in men suffering from asbestosis and other forms of pulmonary fibrosis.¹⁸

Genetic predisposition to development of PMF has been suspected, but remains unproved. The influence of inherited factors that modulate tissue reactivity and fibrotic tendency cannot yet be pinpointed. There is no significant difference in alpha-1 antitrypsin concentrations between controls and patients with PMF.¹⁵ The response of alveolar macrophages to inorganic dust has been demonstrated to be heightened in patients with PMF compared to individuals with simple coal workers pneumoconiosis.¹⁹ Activated macrophages are capable of releasing superoxide anions and hydroxyl radicals that modulate fibroblast proliferation.²⁰

Most recently, investigators have shown that alveolar macrophages of patients with pneumoconiosis are stimulated to produce cytokines that

modulate macrophage function.²¹ Platelet-derived growth factor (PDGF) and Type I insulin-like growth factor (IGF-I) are cytokines that promote fibroblast proliferation. Another cytokine, Type B transforming growth factor (TGF-B), has a protective effect and is found in high levels in patients with simple pneumoconiosis but in low levels in patients with PMF. These observations are reproducible by examining BAL fluid from miners. It is speculated that the degree of alveolar macrophage activation is a host feature. Some miners may develop PMF because of a different qualitative and quantitative profile of cytokine production than the miner with simple pneumoconiosis.²¹

The etiology of PMF remains complex and has numerous triggers. In our patient, zinc was not likely the culprit. Instead, the ore was blasted from sandstone and limestone creating respirable quartz and silicates.

PMF appears to require a critical combination of particle dose, mineral composition, and host predisposition. Further studies will be needed to identify additional factors that enhance or inhibit the PMF process. Until these can be defined, only supportive treatment can be offered.

References

1. Green FH, Laquer WA. Coal workers' pneumoconiosis. *Pathol Ann.* 1980;15:333-410.
2. Gritter HL, Adamson IY, King GM. Modulation of fibroblast activity by normal and silica exposed alveolar macrophages. *J Pathol.* 1986;148:263-271.
3. International Labor Office: Guidelines for the use of ILO international classification of radiographs of the pneumoconoses. Revised edition 1980. *Med Radiogr Photogr.* 1981;57:2-17.
4. Cochrane AL. Relation between radiographic categories of pneumoconiosis and expectation of life. *Br Med J.* 1973;2:532-534.
5. Naeye RL, Mahon JK, Dellinger WS. Rank of coal and coalworkers' pneumoconiosis. *Am Rev Respir Dis.* 1971;103:350-355.
6. Naeye RL. Types of fibrosis in coal workers' pneumoconiosis. *Ann NY Acad Sci.* 1972;200:381-400.
7. Watson AJ, Black J, Doig AT, Nagelschmidt G. Pneumoconiosis in carbon electrode workers. *Br J Ind Med.* 1959;16:274-285.
8. Buschman DL, Ballard R. Progressive massive fibrosis associated with idiopathic hemosiderosis. *Chest.* 1993;104:293-295.
9. Crouch E, Churg A. Progressive massive fibrosis of the lung secondary to intravenous injection of talc. A pathologic and mineralogic analysis. *Am J Clin Pathol.* 1983;80:520-526.
10. Hurley JF, Alexander WP, Hazledine DJ, Jacobsen M, McLaren WM. Exposure to respirable coal mine dust and incidence of progressive massive fibrosis. *Br J Ind Med.* 1987;44:661-672.
11. Williams TJ, Raval B, Ahmad D. Progressive massive fibrosis developing after brief coal dust exposure: evaluation with CT scanning and radionuclide angiocardiology. *J Occup Med.* 1980;22:21-24.
12. McLaren WM, Soutar CA. Progressive massive fibrosis and simple pneumoconiosis in ex-miners. *Br J Ind Med.* 1985;42:734-740.
13. Zaidi SH, Harrison CV, King EJ, Mitchison DA. Experimental infective pneumoconiosis. *Br J Exp Pathol.* 1955;36:553-559.
14. Hart JH, Cochrane AL, Higgins IT. Tuberculin sensitivity in coal workers' pneumoconiosis. *Tubercle.* 1963;44:141-152.
15. Pearson DJ, Mentnech MS, Elliott JA, Price CD, Taylor G, Major PC. Serologic changes in pneumoconiosis and progressive massive fibrosis of coalworkers. *Am Rev Respir Dis.* 1981;124:696-699.
16. Ball JD, Berry G, Clarke WG, Gilson JC, Thomas J. A controlled study of anti-tuberculous chemotherapy in the early complicated pneumoconiosis of coal workers. *Thorax.* 1969;24:399-406.
17. Caplan A. Certain radiologic appearances in the chest of coal miners suffering from rheumatoid arthritis. *Thorax.* 1953;8:29-37.
18. Boyd JE, Robertson MD, Davis JM. Autoantibodies in coalminers: their relationship to the development of progressive massive fibrosis. *Am J Ind Med.* 1982;3:201-208.
19. Turner-Warwick M, Parkes WR. Circulating rheumatoid and antinuclear factors in asbestos workers. *Br Med J.* 1970;3:492-496.
20. Wallaert B, Lassalle P, Fortin F, et al. Superoxide anion generation by alveolar inflammatory cells in simple pneumoconiosis and in progressive massive fibrosis of nonsmoking coal workers. *Am Rev Respir Dis.* 1990;141:129-133.
21. Vanhee D, Gosset P, Wallaert B, Voisin C, Tonnel AB. Mechanisms of fibrosis in coal workers' pneumoconiosis: Increased production of platelet-derived growth factor, insulin-like growth factor type I, and transforming growth factor B and relationship to disease severity. *Am J Respir Crit Care Med.* 1994;150:1049-1055.

The Polymerase Chain Reaction: A Revolutionary New Procedure for the Laboratory Diagnosis of Infectious Disease

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The polymerase chain reaction (PCR) is a revolutionary new means of amplifying, ie, replicating, selected DNA sequences in vitro. This procedure is rapid, requiring approximately 5 hours for completion, and exquisitely sensitive. Studies have shown that as few as one microorganism can be detected. Thus, it has the potential for revolutionizing the diagnosis of infections. Because of its expense, its immediate role will probably be restricted to infections where the causative organism cannot be cultured or is difficult to detect by conventional means. As further progress occurs, however, this technique may well become a major new tool for diagnosing infections.

Significant progress has been made over the last 25 years in understanding the basic molecular processes in biological systems. The wealth of information derived from these studies has led to important advances in methods for the diagnosis and treatment of disease. Among the methods that have emerged is gene amplification. This powerful, new technique involves repeated replication of a selected DNA sequence *in vitro*, ultimately resulting in billions of copies of the selected sequence. The number of copies of the sequence produced allows it to be detected much more readily, providing a revolutionary means of genetic analysis in the clinical laboratory. The great power of this procedure lies in the fact that it literally can detect one gene sequence and, therefore, has exquisite sensitivity.

Although several different procedures have been developed for amplification, the polymerase chain reaction (PCR) was the first, and is currently the most widely used. The purpose of this review is to provide an overview of the use of PCR in the diagnosis of infectious disease.

Basic Principle

The first step of the PCR reaction is to heat the target DNA sequence to 94°C. At this temperature, the hydrogen bonds that attach the two polynucleotide strands are broken, allowing the strands to separate; this is termed denaturation. The temperature is then reduced to a temperature between 35 and 70°C, the actual temperature being dependent on the particular DNA sequence being detected. The reagent mixture contains two short DNA sequences, called primers, that recognize the complementary sequences at either end of the target sequence. At this lower temperature, the annealing temperature, the primers attach to their complementary sequences on either end of the target sequence. The temperature is then raised to 72°C and an enzyme present in the reagent mixture, DNA polymerase, recognizes the unfinished double stranded DNA formed by each primer and its complementary sequence and begins to add nucleotides. A complete complementary copy of each strand is thus produced, fully replicating the target sequence. This cycle of denaturation, annealing, and chain elongation is repeated for a total of 25 to 40 times, eventually producing billions of copies of the target DNA sequence.

The overall process is illustrated in Fig 1. The polymerase, primers, and other associated reagents, called the master mix, are prepared beforehand and stored until they are used. The reaction is performed in 50 to 100 µl of this master mix in a small, plastic tube, which is placed in an instrument called a thermal cycler. This instrument is essentially a highly accurate, programmable heating block, and automatically performs the appropriate temperature incubations.

In initial work, the amplified product was

detected by a technique called a Southern blot. In this procedure the amplification product is separated on an agarose gel and the bands are transferred to a membrane filter. The filter is then hybridized with a complementary DNA probe labeled with a radioactive isotope (DNA probe). Another method is to simply observe for a band of the appropriate size in a polyacrylamide or agarose gel after electrophoresis. Both of these methods are relatively complicated and impractical for routine diagnostic use. A more practical approach for the routine diagnostic setting is colorimetric detection in the wells of a microtiter tray (Fig 2). This is somewhat similar to an enzyme immunoassay but, in this case, amplified DNA is captured on the surface of a well in a microtiter plate by a complementary oligonucleotide (capture probe) attached to the surface of the plastic. Detection is accomplished by a color change that takes place after the addition of an enzyme conjugate and appropriate substrate. This approach has been adopted for the tests currently being developed for marketing to routine clinical laboratories.

Although a major advantage of PCR is exquisite sensitivity, at one point this was also a poten-

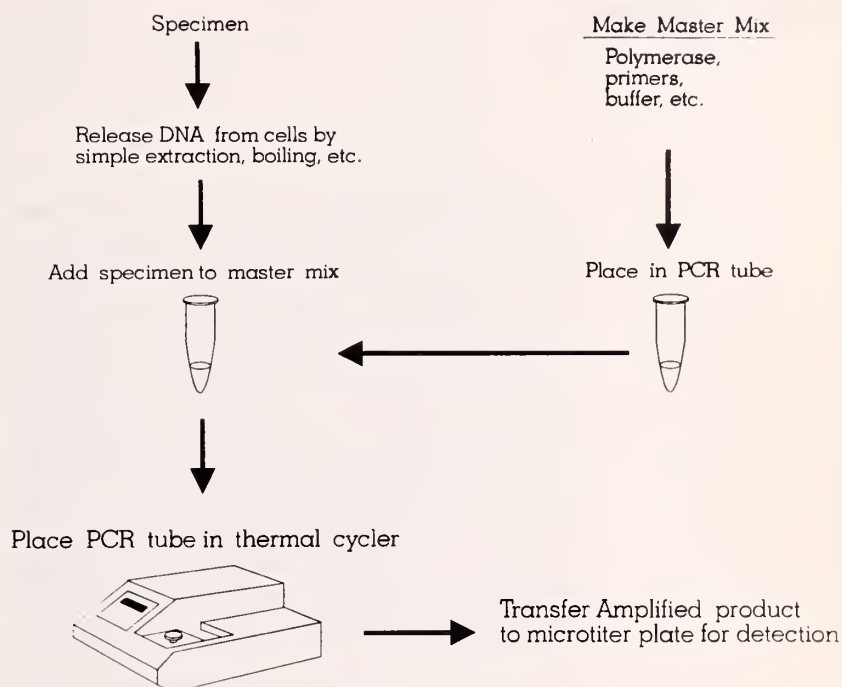


Fig 1 — The procedure for performing PCR involves releasing DNA from the organism in the clinical specimen by boiling or simple extraction, such as treatment with detergent. The master mix, containing polymerase, primers and associated components in suitable buffer, is prepared beforehand and stored until used. After processing the specimen, a small portion of the treated specimen is added to the master mix in a small plastic tube and the tube is placed in a thermal cyclor, which performs the steps for the various incubation temperatures. The amplification product is then transferred to a microtiter plate for detection or analyzed by gel electrophoresis or a DNA blotting technique.

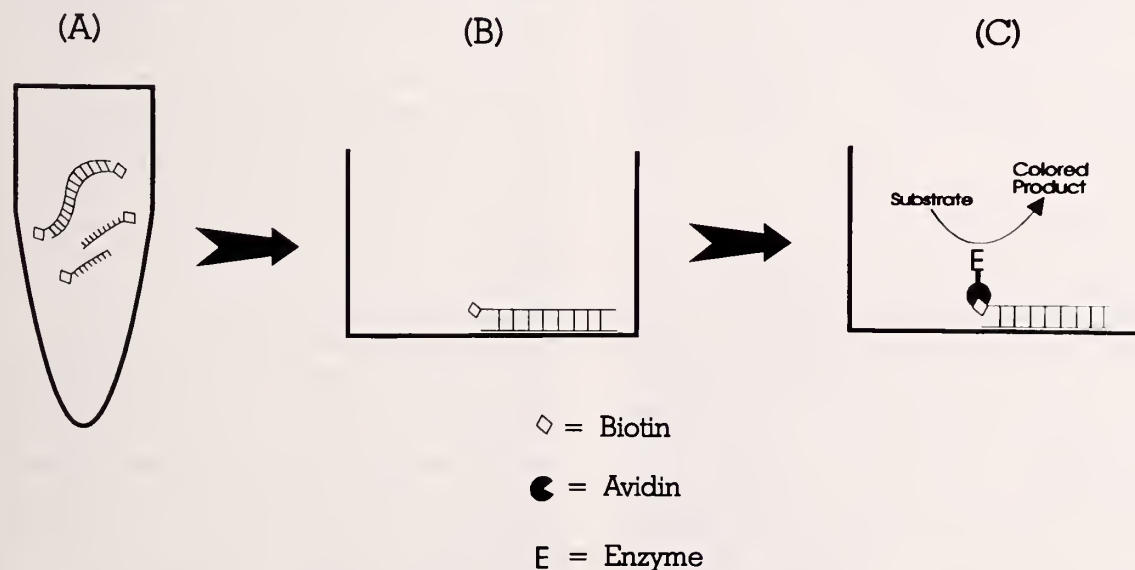


Fig 2 — The most convenient method for detecting amplification products uses a microtiter plate. This is the procedure utilized for the commercial PCR test kits now becoming available. The primers are labeled with biotin (A), so the amplified product is end-labeled with biotin. The product is transferred to the well of a microtiter plate that has a complementary oligonucleotide (capture probe) attached to the surface of the plastic of the wells. The amplified product is incubated in the well and hybridizes with the capture probe (B). An avidin-enzyme conjugate is then added; the avidin attaches to the biotin and the enzyme is conjugated to the avidin (C). When substrate is added, the enzyme produces a colored product from the substrate that can be read on a microtiter plate reader. Production of colored product indicates the target sequence has been amplified, which means the target sequence was present in the clinical specimen.

Polymerase Chain Reaction

tial liability. Since even a single copy of a gene sequence can be detected, contamination of specimens with DNA from either previous amplification reactions or from other specimens processed at the same time can pose a significant risk of generating false-positive results. These two problems have largely been overcome, however. Contamination from previously amplified DNA has been alleviated through the use of an enzyme that recognizes and destroys previously amplified DNA before the reaction is performed. The problem of contamination between specimens processed at the same time has been addressed by introducing stringent procedures for work flow and handling of specimens.

Applications of PCR for Diagnosis of Infectious Diseases

The revolutionary nature of this technique has resulted in the rapid emergence of applications. Because of its commercial potential the PCR process was patented when it was developed and the patent is currently owned by Roche Molecular Systems, a subsidiary of Hoffman-La Roche, Inc. They are developing a number of PCR tests, with the proprietary name "Amplicor," to be licensed by the FDA and marketed as kits. Individual laboratories may also develop their own "in-house" tests, if they pay royalties on tests for which they are financially reimbursed, and a number of hospital and reference laboratories currently offer such tests.

Chlamydia trachomatis

The first PCR test licensed by the FDA for *in vitro* diagnostic use was for *Chlamydia trachomatis* (Amplicor Chlamydia Trachomatis Test) and was approved in June 1993. *C trachomatis* has become a major sexually transmitted pathogen despite efforts of public health agencies. It has been estimated that approximately four million cases of this infection occur in the United States annually.^{1,2} Although cervicitis and nongonococcal urethritis are the most common infections, the organism also causes a significant number of other infections, such as epididymitis,³ endometritis, and pelvic inflammatory disease.⁴ A large proportion of infections in both men and women are asymptomatic.⁵ Because of its prevalence in adolescents and young adults this organism is also responsible for a significant number of cases of conjunctivitis and pneumonia in newborn infants.⁶

A variety of methods have been developed for the detection of *C trachomatis* in clinical specimens.⁷ Culture is the most accurate of the methods that have been available and has, thus, been the reference standard. However, it requires facilities and expertise to perform cell culture, and the fragile nature of the organism necessitates meticulous procedures be used for specimen collection and processing. Other problems include its sensitivity, which has been reported to be only 70% to 80%,⁸ and the time necessary for recovery of the organism. Because of the skill and time required for conventional culture, non-culture methods have been developed which are less technically demanding and provide rapid results. These tests include the direct fluorescent antibody (DFA) test, several types of enzyme immunoassay (EIA) and a DNA probe.⁷ They are generally less accurate than culture, however, with sensitivities ranging between 70% and 100%,^{7,9-11} and specificities around 95%. Although the specificity of these tests is relatively good, false-positive results have been a significant problem. Since *C trachomatis* is a sexually transmitted disease, even a low number of false positive results is an important issue. Therefore, while the non-culture tests are attractive because of their speed and ease of use, their poor performance limits their usefulness.

The Amplicor test amplifies a 207 base pair segment located on the cryptic plasmid, a plasmid whose function is not known but which is found in all isolates of *C trachomatis*. This target sequence was selected because each cell contains about 10 copies of the plasmid, providing a degree of "biological amplification" that enhances the sensitivity of the test. It can be used with urethral or cervical swabs or a urine specimen. When used with a urine specimen it can be utilized as a noninvasive means for detecting asymptomatic infections. The swabs for taking specimens and a special transport medium are available from the manufacturer as a kit. Using the swab provided in the kit, the specimen is collected from the patient and the swab is immediately inserted into the transport medium and swirled. The swab is then removed and discarded and the transport tube, without the swab, is sent to the laboratory. Another advantage of the test is the tube can be transported at room temperature. The time for performing the test is about 4½ hours.

Studies conducted to compare the Amplicor procedure with culture have shown its sensitivity

and specificity to be 91% to 97% and 99.7% to 100%, respectively.¹²⁻¹⁴ In these studies, culture was shown to have a sensitivity of about 85%. Thus, PCR is the first laboratory test to be more accurate than culture and appears to be a major advance in the methods for detection of *C trachomatis*.

The major drawback of the test is the expense and associated equipment. The cost of materials and labor is roughly equal to the cost of culture, but several times the cost of other non-culture tests (unpublished data). The accuracy of other non-culture tests is so much less, however, the added expense of the Amplicor test is probably compensated for by its performance and speed. Conclusive demonstration of this, though, will require a determination of the impact of rapid detection on reduction in spread of the infection.

Mycobacterium tuberculosis

The number of tuberculosis cases reported every year in the United States declined steadily from 1953 until 1985. In 1986, however, the rate began to increase and the upward trend has continued every year since then. The factors responsible for this increase have not been fully identified. In addition, resistance to antimicrobial agents has also emerged as a significant problem. These alarming trends have prompted federal agencies to issue recommendations for more rapid detection and control of these infections.¹⁵ The definitive diagnosis of tuberculosis has relied on culture of the organism from clinical specimens, which is hampered by the slow growth of the organism. With conventional procedures *M tuberculosis* requires up to 6 weeks for growth to be observed. Although the acid fast stain facilitates the diagnosis in many cases, a substantial percentage of patients have a negative stain.¹⁶ The radiometric method for culturing the organism (BACTEC, Becton Dickinson Diagnostic Instrumentation Systems, Sparks, MD) has recently been introduced and appears to be a substantial improvement over conventional culture. This method uses a liquid growth medium containing palmitic acid labeled with carbon-14. Mycobacteria growing in this medium metabolize the palmitic acid, releasing ¹⁴CO₂ and, thus, growth can be detected by measuring the radioactive CO₂ that accumulates in the bottle above the medium. Growth can usually be detected within 7 to 14 days¹⁷ and, when coupled with a rapid identification method such as a DNA probe, the BACTEC method can provide meaningful information much more quickly than conventional

procedures, but still requires a week or more.

A commercial PCR test for *M tuberculosis* (Amplicor Mycobacterium tuberculosis test, Roche Molecular Systems, Inc) is currently being developed for use with sputum or BAL specimens and should be available sometime within the next year. The procedure for this test takes about 5 hours. Two preliminary studies have been completed which indicate the test has a sensitivity of 97% to 100% and specificity of 99.9% to 100%.^{18, 19} Thus, preliminary data suggest this test is about as accurate as culture in detecting this organism but is much more rapid. To begin with, this procedure will probably be an adjunct to conventional methods, since other mycobacteria besides *M tuberculosis* cannot be detected and it will still be necessary to culture the organism to detect antimicrobial resistance. However, in critical cases the rapid results from PCR should allow specific diagnosis and early institution of appropriate chemotherapy.

Human Immunodeficiency Virus (HIV)

HIV infections have assumed a major concern in health care during the last decade. As of June 1991, 182,834 cases of AIDS had been reported in the United States.²⁰ Serological testing, using a combination of the ELISA test and Western blotting, has become the standard means for screening blood products and diagnosing patients, and will probably remain so. There are several areas where PCR may be useful in diagnosing AIDS, however. One is the situation where standard serological testing is inconclusive. Another is the early stages of infection, where antibodies may not have yet developed,²¹ and a third is in infants born to HIV-positive mothers.²² A commercial PCR kit, the Amplicor HIV-1 test, has been developed but is not yet approved by the FDA. The target sequence is proviral DNA integrated into the genome of white cells. Whole blood, with EDTA or citrate anticoagulant, is processed to isolate DNA from the WBCs. This is then amplified and detected with the colorimetric method used for other commercial tests. The total time required for the analysis is about 5 hours.

Other Pathogens

Although PCR procedures have been described for a large number of infectious agents,²³ organisms where this technique may be particularly useful include hepatitis C virus, enterovirus, *Mycoplasma pneumoniae*, *Chlamydia pneumoniae* and *Bordetella pertussis*.

Polymerase Chain Reaction

Future Prospects

The major drawback of PCR, at the present time, is its expense. The cost of the reagents, instrumentation, and special facilities and equipment that are necessary to prevent contamination make the test relatively expensive when compared to more traditional laboratory methods, such as culture or immunological detection. Moreover, this technique has emerged at a time when there are extreme pressures to reduce the cost of medical care. Therefore, even though this technology appears to be far superior to conventional methods, can we afford its use? The answer is probably a qualified yes. For the immediate future, PCR will probably not be used for infections where the pathogen can be recovered readily and inexpensively by traditional means, such as urinary tract infection, upper respiratory infection, and usual soft tissue infections. On the other hand, it may be a significant benefit in serious infections where conventional means are either not available or not reliable, or where the added cost can be offset by reduced hospitalization or more rapid institution of therapy. In these situations the increased accuracy may prove to be a more cost-effective approach. It is also important to point out that this technique is currently in its infancy and further progress is likely to result in a lower cost. In this event, it could well have a major impact on the diagnosis of disease.

References

1. Washington AE, Johnson RE, Sanders LL, et al. Incidence of *Chlamydia trachomatis* infections in the United States using reported *Neisseria gonorrhoeae* as a surrogate. In: Ridgeway OD, Schachter G, Taylor-Robinson J, Ward M, eds. *Chlamydia infections: Proceedings of the sixth international symposium in human chlamydial infections*. Cambridge University Press. 1986:487-490.
2. Washington AE, Johnson RE, Sanders LL. *Chlamydia trachomatis* infections in the United States. What are they costing us? *JAMA*. 1987;257:2070-2072.
3. Berger RE, Alexander ER, Monda GD, et al. *Chlamydia trachomatis* as a cause of acute "idiopathic" epididymitis. *N Engl J Med*. 1978;289:301-304.
4. Schachter J, Grossman M. Chlamydial infections. *Annu Rev Med*. 1981;32:45-61.
5. *Guidelines for the Prevention of Chlamydia trachomatis Infections-1993*. Centers for Disease Control and Prevention, US Public Health Service, Department of Health and Human Services.
6. Schachter J, Grossman M, Sweet RL, et al. Prospective study of perinatal transmission of *Chlamydia trachomatis*. *JAMA*. 1986;255:3374-3377.
7. Barnes RC. Laboratory diagnosis of human chlamydial infections. *Clin Microbiol Rev*. 1989;2:119-136.
8. Lefebvre J, Laperriere H, Rousseau H, Masse R. Comparison of three techniques for detection of *Chlamydia trachomatis* in endocervical specimens from asymptomatic women. *J Clin Microbiol*. 1988;26:726-731.
9. Biro FM, Reising SF, Doughman JA, et al. A comparison of diagnostic methods in adolescent girls with and without symptoms of *Chlamydia* urogenital infection. *Pediatrics*. 1994;93:476-480.
10. Blanding J, Hirsch L, Stanton N, et al. Comparison of the Clearview *Chlamydia*, the PACE 2 assay, and culture for detection of *Chlamydia trachomatis* from cervical specimens in a low-prevalence population. *J Clin Microbiol*. 1993;31:1622-1625.
11. Hosein IK, Kaunitz AM, Craft SJ. Detection of cervical *Chlamydia trachomatis* and *Neisseria gonorrhoeae* with deoxyribonucleic acid probe assays in obstetric patients. *Am J Ob Gynecol*. 1992;167:588-591.
12. Loeffelholz MJ, Lewinski CA, Silver SR, et al. Detection of *Chlamydia trachomatis* in endocervical specimens by polymerase chain reaction. *J Clin Microbiol*. 1992;30:2847-2851.
13. Bass CA, Jungkind DL, Silverman NS, et al. Clinical evaluation of a new polymerase chain reaction assay for detection of *Chlamydia trachomatis* in endocervical specimens. *J Clin Microbiol*. 1993;31:2648-2653.
14. Mahony JB, Luinstra KE, Sellors JW, et al. Role of confirmatory PCRs in determining performance of *Chlamydia* AmpliCor PCR with endocervical specimens from women with a low prevalence of infection. *J Clin Microbiol*. 1994;32:2490-2493.
15. Tenover FC, Crawford JT, Huebner RE, et al. The resurgence of tuberculosis: is your laboratory ready? *J Clin Microbiol*. 1993;31:767-770.
16. Levy JL, Feldman C, Sacho H, et al. A reevaluation of sputum microscopy and culture in the diagnosis of pulmonary tuberculosis. *Chest*. 1989;95:1193-1197.
17. Roberts GD, Goodman NL, Heifets L, et al. Evaluation of the BACTEC radiometric method for recovery of mycobacteria and drug susceptibility testing of *Mycobacterium tuberculosis* from acid-fast-positive specimens. *J Clin Microbiol*. 1983;18:689-696.
18. D'Amato RF, Wallman AA, Hochstein LH, et al. Evaluation of the AmpliCor *Mycobacterium tuberculosis* test for the rapid diagnosis of pulmonary tuberculosis. Abstracts of the General Meeting of the American Society for Microbiology, May 23-27, 1994, Las Vegas, NV, Abstract C-341.
19. Metchock B, Diem L. Clinical Laboratory evaluation of the Roche AmpliCor *Mycobacterium tuberculosis* assay. Abstracts of the 34th Interscience Conference on Antimicrobial Agents and Chemotherapy, October 4-7, 1994, Orlando, FL, Abstract D79.
20. Centers for Disease Control. HIV prevalence estimates and AIDS case projections for the United States: report based upon a workshop. *MMWR Morb Mortal Wkly Rep*. 1993;42:481-486.
21. Sheppard HW, Busch MP, Louie PH, et al. HIV-1 PCR and isolation in seroconverting and seronegative homosexual men: absence of long-term immunosilent infection. *J AIDS*. 1993;6:1339-1346.
22. Petru A, Dunphy MG, Azimi P, et al. Reliability of polymerase chain reaction in the detection of human immunodeficiency virus infection in children. *Pediatr Infect Dis J*. 1992;11:30-33.
23. Persing DH, Smith TF, Tenover FC, White TJ, eds. *Diagnostic molecular microbiology: principles and applications*. American Society for Microbiology, Washington, DC, 1993.



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Noncompetition Agreements in Kentucky Health Care

Scott W. Dolson

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Two recent events have dramatically affected the ability of Kentucky's health care providers to enforce noncompetition agreements. First, the Kentucky General Assembly enacted KRS 311.285. This statute declares that noncompetition agreements between health care providers are contrary to public policy and are void and unenforceable if their term is for one year or longer. Second, the Kentucky Board of Medical Licensure issued a statement that Kentucky physicians who attempt to enforce noncompetition agreements may be subject to disciplinary action by the Board, on the grounds that such conduct is unethical.

Sweeping aside Kentucky court decisions dating back 100 years, the enactment of KRS 311.285 raised a number of unanswered questions. Does KRS 311.285 apply retroactively to noncompetition agreements entered into before the statute's July 15, 1994, effective date? KRS Chapter 311 deals with the regulation of physicians; does this mean that KRS 311.285 applies only to physicians? KRS 311.285 refers to the enforcement of noncompetition agreements "upon the severance of any relationship between the health care providers"; does this mean that KRS 311.285 does not apply to noncompetition agreements entered into in connection with practice acquisitions?

The Board's policy statement provides little guidance regarding the circumstances under which the Board will take disciplinary action against Kentucky physicians attempting to enforce noncompetition agreements.

This article summarizes the current state of the law in Kentucky, addresses the difficult issues left unanswered by KRS 311.285 and the Board's policy statement, and suggests a solution for restructuring noncompetition agreements.

Pre-KRS 311.285 Law and the Nazar Case —
In a line of cases dating back to 1887, Kentucky's

highest courts consistently enforced noncompetition agreements involving physicians, so long as the agreements were reasonable with respect to their "character, duration, and territorial extent." Underlying these decisions was the judiciary's respect for the freedom of professionals to enter into binding contracts, and the recognition that valuable consideration was often given in return for noncompetition agreements. At the same time, in a line of ethics opinions dating back to 1960, the American Medical Association concluded that noncompetition agreements should be discouraged as not being in the public interest. Against this divided backdrop, the controversial case involving Gregory Nazar, MD, exploded onto the scene during March 1994.

Dr Nazar is a Louisville based pediatric neurosurgeon. During his tenure at the Neurosurgical Institute of Kentucky, PSC ("NIK"), Dr Nazar established several notable programs, including a surgical procedure for cerebral palsy patients referred to as a selective dorsal rhizotomy, a cure for a special type of tethered cord syndrome, and experimental procedures utilizing a "Baclofen Pump." Between 1988 and 1993, Dr Nazar performed approximately 300 surgeries on pediatric patients annually and was known both locally and nationally for his work with children. Dr Nazar also executed a written employment agreement that included an agreement not to practice in his medical specialty for a period of 2 years after termination of his employment with NIK, within a radius of 50 miles of any office or clinic of NIK.

Certain incidents culminated in Dr Nazar's resignation from NIK during December 1993. Dr Nazar stated in court pleadings that upon his resignation, he immediately commenced searching for work in other cities, but reconsidered his decision to leave because so many physicians and patients urged him to stay in Louisville. Dr Nazar began practicing pediatric neurosurgery in March

1994 with Jelsma, Jelsma & Lee, PSC, a Louisville based practice group. During that same month, NIK was successful in obtaining a restraining order from the Jefferson Circuit Court prohibiting him from practicing in violation of his noncompetition agreement.

As the matter was aired in Jefferson Circuit Court, the Nazar case generated an outpouring of negative publicity and an unprecedented backlash against the enforcement of physician noncompetition agreements. The fact that Dr Nazar worked with hundreds of severely ill children whose parents placed a tremendous amount of faith and hope in his skills put the enforcement of physician noncompetition agreements in the worst possible light. The Jefferson Circuit Court's restraining order was sustained by the Kentucky Court of Appeals, but the intense publicity forced a quick settlement of the case. Dr Nazar continues to practice pediatric neurosurgery in Louisville.

Analysis of KRS 311.285. — The shock waves produced by physician noncompetition cases reached Frankfort in time for the last minute inclusion of KRS 311.285 in Kentucky's 1994 health care reform legislation. KRS 311.285 was first proposed as a floor amendment on March 21, 1994, by Tom Smith of Elizabethtown; the health care reform legislation was approved on April 15, 1994. Senator Smith stated that the bill was in response to several incidents where physicians practicing in small towns split away from their partners and were forced to leave the community to work, even though their services were badly needed in that community. KRS 311.285 reads as follows:

1. It is the finding of the General Assembly that the American Medical Association and Kentucky Medical Association have determined that agreements between health care providers that allow or encourage the enforcement of contractual provisions by which one (1) health care provider agrees not to compete against another health care provider or group of health care providers for a period of time upon the severance of any relationship between the health care providers is unethical. It is further the finding of the General Assembly that these agreements serve to increase health care costs by creating a barrier in the physician and patient relationship which forces the patient to seek alternate care from another health care provider, even if the original treating provider remains in the community.

It is therefore the finding of the General Assembly that these agreements are contrary to the public policy of the Commonwealth.

2. An agreement between health care providers that allows or encourages the enforcement of contractual provisions by which one (1) health care provider agrees not to compete against another health care provider or group of health care providers for a period of time upon the severance of any relationship between the health care providers shall be void as against public policy and not enforceable if the period of time is for one (1) year or longer.

KRS 311.285 undoubtedly prohibits the enforcement of noncompetition agreements if (i) the agreement is among physicians, (ii) the term is for one year or more, (iii) the enforcement of the agreement arises out of the severance of a relationship, and (iv) the agreement was entered into after July 14, 1994. The impact of KRS 311.285 on the many noncompetition agreements that do not fall squarely within its scope will remain in doubt until the various issues discussed in this article are tested in Kentucky's courts.

Definition of "Health Care Provider" — The most significant issue left unanswered by KRS 311.285 is what exactly constitutes a "health care provider." KRS 311.285 and Kentucky's other health care laws do not define "health care provider." KRS 311.285 is included in the KRS Chapter dealing with "Physicians, Osteopaths and Podiatrists," and KRS 311.285(1) addresses noncompetition covenants in the context of "the physician and patient relationship," both of which suggest that the General Assembly was thinking primarily about noncompetition agreements restricting physicians (ie, the Nazar case). Certainly physicians and physician entities (eg, PSCs, professional limited liability companies and partnerships) fall within the scope of KRS 311.285. The General Assembly could have made it clear, however, that the scope of the statute was limited to physicians, but either intentionally or inadvertently failed to do so. As a result, KRS 311.285 could be interpreted as also applying to non-physician health care providers (eg, hospitals or nursing homes). The reference to "health care provider" also raises the question of whether entities that do not "provide" health care services fall outside of the scope of KRS 311.285, even when they are enforcing noncompetition agreements against physicians. For example, if a management

Noncompetition Agreements

company acquires the assets of a physician practice group, and contracts with the physicians for their services, could the management company enforce a 5-year noncompetition agreement against the physicians?

Term of the Noncompetition Agreement —

Another issue arises if the term of a noncompetition agreement is for one year or more. In that situation, KRS 311.285(2) may be read to provide that the agreement is void and unenforceable, even with respect to the first 364 days of the noncompetition agreement's term. Noncompetition agreements that are for exactly one year are void and unenforceable, which means that an enforceable noncompetition agreement cannot extend beyond one year *minus* one day. A court might "reform" an agreement that extends beyond 364 days in order to allow it to be enforceable for that limited term, but noncompetition agreements should be drafted with the 364 day term limit in mind.

Additional issues are raised by the division of KRS 311.285 into two separate sections, the first of which (KRS 311.285(1)) states the legislature's public policy concerns, including a finding that "noncompetition agreements are contrary to the public policy of the Commonwealth," and the second of which (KRS 311.285(2)) provides that agreements that are for one year or more are void and unenforceable. A court might interpret the division of KRS 311.285 into two freestanding provisions as authority for refusing to enforce a noncompetition agreement that qualified under KRS 311.285(2) (not extending beyond one year *minus* one day), or as support for finding that noncompetition agreements entered into prior to the effective date of KRS 311.285 were in contravention of public policy and unenforceable, in each case on the theory that KRS 311.285(1) was merely an articulation of the already discredited status of noncompetition agreements.

Situations Where KRS 311.285 Applies —

Another issue raised by the language of KRS 311.285 is exactly what constitutes the "severance of a relationship." This language suggests that KRS 311.285 applies only in situations where the enforcement of a noncompetition agreement is arising out of the termination of an employment relationship or a practice breakup, and not to noncompetition agreements entered into between unrelated parties in connection with a practice acquisition or the purchase or sale of a

health care facility's assets. It would not be surprising if the courts on public policy grounds expanded the language of KRS 311.285 (in a *Nazar* type scenario), to situations where the agreement did not arise out of the "severance of a relationship."

Pre-July 15, 1994 Noncompetition Agreements —

The general rule in Kentucky, which can be found both in statutes (KRS 446.080(3)) and case law *Dean v Gregory*, Ky, 318S.W.2d 549 (1958), is that a statute will not be applied retroactively unless the legislature expressly provides for retroactive application, if such application would impair vested rights. This reading of Kentucky law supports a conclusion that noncompetition agreements entered into prior to July 15, 1994, are not subject to KRS 311.285. The decision of the Fayette Circuit Court in *Bluegrass Hematology Oncology, PSC v John Gohmann, MD*, Case No. 92CI-281 (June 28, 1994), however, places that conclusion in question. The *Gohmann* case involved the enforcement of a pre-KRS 311.285 noncompetition agreement. The Fayette Circuit Court concluded in its opinion that "the statement of public policy expressed by the legislature [by enacting KRS 311.285] is merely a verbalization of public policy which had been in existence prior to the enactment. In other words, the legislature merely stated the obvious." The Court stated that it had "no difficulty in saying that any action entered into by a physician which detrimentally affects a patient is void or voidable as against public policy, while at the same time saying that such agreements entered into between two knowing persons are enforceable to the extent that they affect money."

The Fayette Circuit Court's conclusion that KRS 311.285 at least in part should be applied retroactively finds some support in the language of KRS 311.285(1), which refers to American Medical Association and Kentucky Medical Association ethics opinions and policies that were in existence long before the statute's July 15, 1994, effective date. On the other hand, it is strong medicine for a court to reach such a conclusion in spite of the long line of Kentucky decisions consistently enforcing physician noncompetition agreements.

Kentucky Board of Medical Licensure Policy Statement —

While the *Nazar* case was pending in the Jefferson Circuit Court, a group called Parents Demanding Quality Care, made up of fami-

lies of about 200 children treated by Dr Nazar, filed a grievance with the Board claiming that NIK's attempt to enforce the noncompetition agreement against Dr Nazar was an ethics violation. The *Nazar* case settled before the Board acted on the grievance. The Nazar grievance and the enactment of KRS 311.285 apparently focused the Board's attention on the issue of physician noncompetition agreements, resulting in the issuance of a policy statement in the Board's Winter, 1995 Newsletter:

The AMA *Opinions on Professional Rights and Responsibilities* (9.02) discourages agreements between physicians which restrict the right of a physician to practice medicine upon termination of his employment. It concludes that such restrictive agreements are not in the public's best interest. By enforcing the restrictive covenant prohibiting a physician from practicing, the patients are denied the right to select a physician of their choice which is in violation of the *Opinions on Professional Rights and Responsibilities of the AMA* (9.06). The Medical Practice Act, KRS 311.530 adopted the standards enunciated in the *Principles of Medical Ethics* and the *Code of Ethics* of the American Osteopathic Association. The Board may take disciplinary action against a Kentucky physician who enforces or attempts to enforce a "no-compete" clause against another physician because such conduct is deemed unethical.

Based on written communications and conversations with the Board's counsel, it appears that the Board has concluded that there is a possibility of patient harm in the enforcement of physician noncompetition agreements. The Board considers the enforcement of a physician noncompetition agreement that results in patient harm to be unethical behavior. A physician that engages in unethical behavior is subject to disciplinary action by the Board.

In the Board's opinion, there is no bright line test to determine whether the enforcement of a particular noncompetition agreement would result in patient harm. Patient harm is most likely to arise in situations where a specialist is prevented by a noncompetition agreement from seeing patients in a geographic area where the patients do not have reasonable access to alternative specialists. The Board will review cases as they arise by examining whether enforcement of the particular noncompetition agreement will result in patient harm. The Board's determination

of whether the enforcement of a noncompetition agreement results in patient harm and is unethical would not be affected by the 1-year provision in KRS 311.285 (eg, a 6-month noncompetition agreement could trigger a disciplinary action by the Board if there is a finding of patient harm).

Conclusions and Possible Planning Alternative

— The enactment of KRS 311.285 was apparently a reaction by the legislature to the impossible bad facts of the *Nazar* case. As an example of what Oliver Wendell Holmes, Jr meant by the statement "Great cases like hard cases make bad law," KRS 311.285 deals effectively with the public policy concern of protecting patients, the issue of paramount importance in the *Nazar* case, but ignores the other side of the coin — the case where a young physician is brought to the community by an established practice, obtains training and patients through the affiliation, and abruptly departs with the patients to establish a competing practice. In that situation, there should be a way to protect the established practice, which has relied on the departing physician to its economic detriment, while at the same time addressing any public policy concerns arising out of the possibility of patient harm.

The decision of the Fayette Circuit Court in *Bluegrass Hematology Oncology, PSC v John Gohmann, MD* suggests a possible solution to the conflict between the public policy concerns surrounding physician noncompetition agreements and the freedom to enter into contracts relating to economic issues. The Court found that while it was not appropriate for public policy reasons to enjoin Dr Gohmann from seeing his patients, even if seeing those patients violated a noncompetition agreement, the Court could award damages for breach of contract. KRS 311.285 speaks in terms of agreements where one health care provider agrees not to compete with another health care provider, not agreements that require payment of fees or damages for leaving a practice.

The distinction identified by the Fayette Circuit Court rests in the difference between obtaining a restraining order or injunction against a health care provider prohibiting that provider from continuing to see certain patients, which might result in patient harm, and the mere payment of compensation among health care providers, which should not result in patient harm but still addresses valid economic concerns. The public policy concern that a physician might be restrained from seeing patients would not be vio-

Noncompetition Agreements

lated by the payment of damages, so long as the payments are not so excessive that they would cause a reasonable physician to decide not to compete in lieu of paying the damages. The payment might be structured as a form of predetermined or "liquidated" damages, payable by a departing physician for the right to compete against the physician's former employer or partners. The drafting of this alternative to the noncompetition agreement would require careful consideration of the possible impact of various federal and state health care laws and would undoubtedly be tested in the courts by an unhappy party to such an arrangement. The only alternative in Kentucky, unfortunately, is to operate within the narrow and uncertain confines of KRS 311.285.

Information for Authors

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References — References must be typed in double spacing on separate sheets and numbered consecutively as they are cited. They should include (in this order) the authors' names and initials, title of article (and subtitle if any), abbreviated name of journal, year, volume number, inclusive page numbers. Follow the AMA style currently in use, abbreviating the names of journals in the form given in *Index Medicus*. Authors are responsible for reference accuracy.

Illustrations — Illustrations must be submitted in duplicate and the sequence number and author's name should appear on the back of each. Legends for illustrations should be typewritten (double-spaced) on a separate sheet. The author will be billed for the cost of reproduction of illustrated material for publication in excess of three average illustrations and/or tables. Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source.

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Use of Laparoscopy in the Treatment of Acute and Chronic Right Lower Quadrant Pain

The article by Drs Morfesis and Ahmad ("Use of Laparoscopy in the Treatment of Acute and Chronic Right Lower Quadrant Pain," Vol 94:1, pp 16-21), though an interesting review of the activities of a rural surgical practice, adds very little to the scientific literature regarding the appropriate management of lower abdominal and pelvic pain.

The significance of the number of patients who underwent diagnostic laparoscopy with no remarkable pathological findings is impossible to determine without information regarding the number of patients who presented with abdominal pain and did not undergo surgical evaluation. The paper suggests that all such

patients were evaluated surgically, but that may not be the case.

The conclusions drawn by the authors are not supported by the study they have reported. To conclude that the patients with chronic pain who underwent laparoscopic evaluation and treatment experienced relief of that pain without having fully surveyed those patients for long-term results is unwarranted.

Many of the patients listed had gynecologic problems which generally do not require surgical intervention. I am unable to determine from the article the extent to which these patients were evaluated gynecologically prior to these procedures, but in most instances, the diagnosis of these disorders does not require surgery, and surgery is not necessary to treat them.

Finally, I would agree that there is more to evaluating the appropriateness of a surgical

procedure than the "pathological status of the appendix."

Unfortunately, those other factors were not discussed in the paper, and as a result, the appropriateness of many of the procedures reported could not be assessed.

Analysis of the costs and benefits of various options of management is incomplete without also considering the option of nonsurgical management when appropriate. Even though a number of the procedures reported were likely unnecessary when evaluated retrospectively, it is possible that sufficient indications existed to justify surgical management when viewed contemporaneously. A more complete discussion of those patients who were not felt to have indications for surgery would have been a useful addition to this report.

Larry P. Griffin, MD, FACOG
Washington, DC

Letters To The Editor

The Editorial Board of the *Journal of the Kentucky Medical Association* welcomes comments, criticisms, recommendations, and observations from all its readers. Please submit letters to:

Editor
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The Patient's Last Advocate

An advocate, in conventional vernacular, is defined as someone who speaks for or pleads a cause for another. Implicit in this definition is that the persons represented by the advocate cannot effectively defend or argue their position without the intercession of someone more capable of doing so. In the case of health care, if medicine is truly becoming more "industrialized" and depersonalized by converging forces of big government, big business, and unrelenting socioeconomic forces, then who shall assume the advocacy for the patient?

"As it ethically and morally must, the advocacy of the patient is to be borne now more than ever solely by the physician."

Government, at the Federal or State level, cannot in good faith purport to represent the best interests regarding the health of its populace. Time has gone when government intervention was absolutely necessary to correct the abuses of industry in the workplace and environment, redress the unregulated processing of foods or disposition of pharmaceuticals, and exercise control regarding the training and licensure of health care professionals. Spurred on by the Great Depression, the Federal government assumed ever greater regulatory controls until it has

become bloated, bankrupt, and incapable of resolving societal needs without further, onerous regulations. The clarion call today is for less government, less services, and reduced payments under the banner of cost effectiveness and balancing of the budget. Under these constraints, patient advocacy by government is subservient to political and budgetary expediencies, no matter what political leaders would have us believe.

The concern for patient advocacy is no less dire when one examines the priorities of insurance carriers and of health care management industries. The common denominator for both systems cannot long remain in question when physicians are regarded as "production workers" involved in a process of health care "delivery systems" to their "clients," processes becoming progressively subject to outcome comparisons, analyses of provider "performance," and cost competitiveness. The patient, or client, is now considered a purchaser of health care and, as such, is regarded as a "unit of production" when fully restored to health as determined by "optimal production functions." Can anyone seriously argue that humanism and empathy are of any consequence to systems wherein their clients are thought of in the context of units of production?

Nor can the legal system claim convincingly to uphold the rights of the patient. To be sure, no group collectively can avert the stain of bias, of self interest or hypocrisy. Yet by its very nature the legal system is designed to uphold the rights of the patient usually after an alleged negligence has occurred; it is more common than not to see a case prosecuted in terms of its potential

"... patient advocacy by government is subservient to political and budgetary expediencies, no matter what political leaders would have us believe."

gain rather than merit, its profitability rather than purpose. It is a rhetorical question as to how often true rather than perceived medical negligence is redressed by the courts. It is equally naive to believe that surveillance of data banks of physician performance outcome, or the vigorous pursuit of possible Medicare/Medicaid abuses will any better accomplish or assure quality health care and the protection of the health and rights of the individual.

As it ethically and morally must, the advocacy of the patient is to be borne now more than ever solely by the physician. It is a responsibility we have too often abrogated or neglected, to be taken up by others as usurpers to our role. We have taken the Hippocratic oath not to protect our pocketbook, bureaucracies, stockholders' dividends, the status quo, nor even statutes or bills, but to protect the health and welfare of our patients. To us is entrusted that care and concern, and it must not be squandered nor relegated to others by design or default. We, as physicians, have become the patient's last advocate.

Jaroslav P. Stulc, MD



Marla Vieillard

KMA Alliance Annual Convention April 22 to 24, 1996 Ashland, Kentucky

All physician spouses are invited to attend the 74th Annual Convention of the Kentucky Medical Association Alliance. We will meet at the Ashland Plaza Hotel. Some members will start arriving on Sunday, April 21st. At each annual convention we renew old friendships and make new ones. The business sessions finish the 1995-1996 year. On Tuesday, April 23rd, we will honor our outgoing and incoming Board officers. This event will take place at the Mayo Mansion which has recently been refurbished and is the headquarters for RAM TECHNOLOGIES. The Sugarbush carriages will take us back and forth.

A condensed version of the schedule is printed in this *Journal*. A full schedule and registration form will be in the "Blue Grass News," or contact your County Alliance Presidents. If you live in an unorganized county you may contact Jean Wayne at the KMA office 1-502/426-6200. She can mail you a registration form. The hotel has blocked off a group of rooms together. To make reservations, call

1-800/346-6133 or Fax: 1-606/325-4513. Mention that you are with the KMAA convention and you want the convention room rate.

Our national guests will be Mrs Colleen Adams from the AMAA and Mrs Jan Meyer from SMAA. The surrounding state presidents have also been invited.

Ms Cathy Cronkite will be our educational guest speaker on Monday eve before dinner. This lecture/talk is free to the public and all members attending the convention. Ms Cronkite will discuss her trials with depression, fighting this illness, and getting help. "Treat it and Defeat it" is the title of her presentation.

On the entertainment side, we will have a fashion show by The French Shoppe of Nashville during lunch Monday. You may bring a guest to this lunch. On Tuesday, Aunt Mattie will visit and give us an injection of laughter. The second annual basket auction for McDowell house will follow. We are raising funds to help them hire an Educational Director. Then the Awards for Doctors' Day, Membership,

Medical Heritage, and AMA-ERF will be given. The boutique for AMA-ERF will be open Monday and Tuesday 10 am to 5 pm at the hotel.

Tuesday evening we honor our incoming President, Ruth Ryan. As mentioned, we will start at the Mayo Mansion and then return to the hotel for dinner. The theme is "April in Paris." Dr Danny Clark will bring greetings from the KMA, and Dr James Crase will bring us up to date on "How Are We Doing in Frankfort?" Mrs Colleen Adams, AMAA representative, will install our '96-'97 officers.

Our year has been filled with many great projects and activities. Thank you to all members who have made this another exceptional year. I have been honored and privileged to serve you. Thank you to the KMA, the KMA staff, Jean Wayne, and our KMAA leadership for their support this past year.

**Marla Vieillard
KMAA President**

1996 Convention Schedule of Events

Sunday, April 21 (Eastern Standard Time)

- 6-10 PM Hospitality suite open — complimentary light supper
- 8-9 PM Informal reception for county presidents-elect and state president-elect

Monday, April 22

- 7:30-12 NOON Hospitality suite open — complimentary continental breakfast
- 9-12 NOON Registration
- 9-10 AM Membership Committee/Finance Committee
- 10-12 NOON Executive Committee/Bylaws Reference Committee hearing
- 12-12:45 PM Lunch
- 12:45-1:30 PM FASHION SHOW by French Shoppe, Nashville
- 1:30-3 PM Shopping at French Shoppe Show and AMA-ERF boutique vendors
- 3:05-4:15 PM Pre-Convention Board Meeting
- 4:15-6 PM Shop, rest, get ready for evening events
- 6:30 PM KATHY CRONKITE, guest speaker
- 8 PM Dinner

Tuesday, April 23

- 7:30-9 AM Hospitality suite open
- 7:30-9 AM Registration
- 9-12 NOON House of Delegates
- 12:30-3 PM Luncheon honoring past KMAA Presidents, Out-of-State Presidents, Members-at-Large; Speaker — "AUNT MATTIE GOOCH" 2nd Annual BASKET AUCTION for McDowell House
- 3:15-4:15 PM Transitional Meeting
- 5:45 PM Reception honoring Ruth Ryan and '96-97 Board at Mayo Mansion
- 7:45 PM Dinner at hotel
- Danny Clark, MD, KMA President; Senator James Crase, MD; presentation of AMA-ERF checks; awards; installation of '96-97 KMAA President and Board by Colleen Adams, AMAA Treasurer

Wednesday, April 24

- 7:30-9 AM Hospitality suite open
- 9-10:45 AM Post Convention Board Meeting

Room Reservations: Ashland Plaza Hotel, 1-800/346-6133. State you are with the Kentucky Medical Association Alliance. Room rate — \$79.00 plus 6% state tax and 3.5% tourism tax. A block of rooms will be held on the 9th and 10th floors.

FYI

- Monday's Committees and Pre-Convention Board — attended by the designated 1996 Board members. AMAA and SMAA guests are welcome.
- House of Delegates — attended by all KMAA Board members, outgoing and incoming county presidents, delegates, alternate delegates, AMAA and SMAA representatives and guests.
- Transitional Board meeting — attended by all outgoing and incoming KMAA Board members and county presidents.
- Post Convention Board Meeting — attended by all 1996-1997 Board members and incoming county presidents. Guests are welcome.

KMA BOARD OF TRUSTEES SPECIAL CALLED MEETINGS

February 7, 1996

A special called meeting of the KMA Board of Trustees was held on Wednesday, February 7, 1996, at Frankfort Country Club, to discuss Governor Patton's proposed legislative health care package. Lieutenant Governor Stephen L. Henry, MD, presented the Governor's plan to the Board.

After the Lieutenant Governor's comments and discussion by the Board, the Board reaffirmed Resolution B, as adopted by the 1992 KMA House of Delegates, which outlined the Association's state legislative policies and authorized the Legislative Quick Action Committee to establish legislative positions determined to be in the best interest of the Association and its membership.

March 3, 1996

The KMA Board of Trustees met in special session Sunday, March 3, 1996, at the Hyatt Regency Hotel in Louisville, to discuss the business that would come before the Special Session of the House of Delegates, scheduled to meet in one hour. Additionally, the Board adopted Resolution B, Legislative Policy, for presentation to the House of Delegates during the Special Session.

PEOPLE

D. Mark Bickers, MD, a cardiologist with Cardiovascular Associates of Southern Indiana in New Albany, has been elected chief of the Medical Staff of Floyd Memorial Hospital and Health Services for 1996.

Robin Floyd, MD, Immediate past president of the KMA Resident Physicians Section, and a U of L Diagnostic Radiology Resident, has been named recipient of the AMA/Glaxo Achievement Award. The award, which recognizes medical students and resident physicians who have demonstrated strong nonclinical leadership skills in medicine or community affairs, was presented during the 1996 AMA National Leadership Conference, March 9-13, in Washington, DC. **Judy M. Linger, MD**, Chair, KMA Resident Physicians Section, made the presentation.

KMA members elected to the 1996 medical staff for Tri-County Baptist Hospital, LaGrange, are **Donald V. Welsh, MD**, otolaryngology, President-Elect, and **Linda F. Lucas, MD**, anesthesiology, Secretary-Treasurer. Elected department chairs and vice chairs were the following: Department of Medicine — **P. Keerthi Kemparajurs, MD**, family practice, chair; **Steven D. White, MD**, family practice, vice chair; Department of Surgery — **Virginia R. Stokes, MD**, ob/gyn, chair; and Perinatal Department — **Carl D. Paige, MD**, internal medicine/pediatrics, chair.

UPDATES

Medicine Receives \$5.3 Million Gift

U of L has received \$5.3 million from Jewish Hospital to finance

cardiothoracic research at its School of Medicine. Funds will support work led by cardiothoracic surgeon **Laman A. Gray, MD**, a faculty member.

According to a report from the University, Dr Gray's team will use the money to refine techniques such as:

- the use of lightweight ventricular assist devices (VADs) as a long-term bridge for heart transplant candidates awaiting a donor. Technological advances have reduced the VADs' external support system from a 300-pound console on wheels to three battery packs (each about the size of a deck of cards) that can be carried in an over-the-shoulder pack.

- cardiomyoplasty, in which a back muscle is detached, wrapped around the heart and trained with a pacemaker to beat with the ailing heart, augmenting its ability to contract.

- minimally invasive surgeries that involve three-inch instead of whole-chest incisions for some heart and lung procedures. Such measures don't require heart and lung bypass, and patients recover much faster while reaping the benefits of advanced heart and lung surgical techniques.

U of L has cooperated with Jewish Hospital on several state and regional firsts including Kentucky's first heart, heart/lung, pancreas and liver transplants, cardiomyoplasty and use of the Novacor ventricular assist device. U of L medical students in 14 specialties receive training at Jewish Hospital.

"This gift is one of the largest ever received by the university," said **Donald R. Kmetz, MD**, U of L's vice president for health affairs and dean of the medical school. "Its impact will be felt far beyond the medical school."

KMA-RPS Receives AMA Grants

The KMA-RPS has been awarded two

AMA Policy Promotion Grants for service projects undertaken in accordance with the direction of the RPS and/or its members. The first grant, awarded in November 1995, helped to fund the Annual Meeting program of the RPS which took place in September. The project coordinator for this grant was **Robin Floyd, MD**.

KMA-RPS Delegate to the AMA-RPS and UK pathology resident **Donna Skinker, MD**, coordinated a policy grant application for the First Aid for Children Today program in conjunction with the Girl Scout Mentoring Program. This grant, which will fund the printing and distribution of materials to promote safety and first aid to school children, was awarded in January 1996.

Capitation Handbook Available

While nationwide 4% of total physician revenues were capitated in 1994, 35% of physicians with managed care contracts had some capitated revenues, and these figures may be increasing. To aid physicians in assessing the financial risks of capitation, the AMA has published *Evaluating Capitation Payments: A Guide to Calculating Benchmark Capitation Rates*. The content was developed by the Center for Health Policy Research utilizing a database of actual private sector claims.

The guide presents fee-for-service based capitation rates that can be used to construct benchmark per-member, per-month payment rates for two types of contracts or bundles of physician services — a global contract covering all physician services and a contract covering a group of primary care services. The capitation rates are stratified by state, gender, and age group. Illustrations describing how to use the rates to construct estimated payments for the model contracts are also presented.

The AMA is currently providing the guide free to AMA members.

AMA Seeks Removal of Gag Rules in Managed Care

The AMA recently issued a statement calling for managed care plans to eliminate so-called "gag" rules from their provider contracts that prevent physicians from discussing with patients treatment options that may not be covered by their health benefit plans.

In addition to limiting physicians' ability to discuss treatment alternatives with their patients, gag rules also may prevent physicians from referring very ill patients for specialized care by providers outside the plan.

AMA pledged to stand behind physicians who believe that a health plan's gag rule or similar policy may prevent them from fulfilling ethical duties to their patients. Physicians may call AMA at 1-800/AMA-1066 or 312/464-4367.

Interested in Serving as an Officer for AMWA?

Women physicians interested in serving as an officer for the Kentucky branch of the American Medical Women's Association (AMWA) are encouraged to contact **Leah J. Dickstein, MD**, Professor, Department of Psychiatry and Behavioral Sciences, University of Louisville School of Medicine, phone 502/852-6185 or fax 502/852-8937. Dr Dickstein is a past president of AMWA.

Covera-HS™ — Searle's New Once-Daily Antihypertensive/Anti-Anginal Product Approved by FDA for Marketing

Searle, the pharmaceutical subsidiary of Monsanto Company, announced recently that it has received US Food and Drug Administration approval for Covera-HS (verapamil hydrochloride).

Searle reports that Covera-HS is

the first once-daily formulation of an antihypertensive/anti-anginal agent that uses an advanced tablet coating and a novel drug delivery system to mimic the body's typical 24-hour circadian variations in blood pressure and heart rate. This unique delivery technology, called COER-24™ (Controlled-Onset-Extended-Release), was developed in conjunction with ALZA Corporation.

Available in both 180 mg and 240 mg tablets, Covera-HS is designed for oral dosing at bedtime. Peak concentration of Covera-HS is delivered in the early waking hours when blood pressure and heart rate are rising at their highest rate. There is minimal drug delivery during sleep when blood pressure and heart rate are at their physiologic lowest.

Covera-HS' advanced COER-24 delivery system consists of two stages. First, it provides for a 4- to 5-hour delay in drug release after bedtime administration. At approximately 3 hours before awakening, drug release occurs so that peak levels of medication coincide with waking and the first hours of activity. Second, the extended release of drug in the gastrointestinal tract provides 24-hour control of blood pressure and symptoms of angina pectoris.

US Justice Department Closes Investigation of KMA

The US Justice Department has ended its nearly 7-month investigation of KMA's alleged role in encouraging physicians to withdraw from Kentucky's Medicaid program. KMA learned recently that the investigation is now closed and that no action will be taken against the Association. This resolution confirms KMA's contention that it did nothing improper or illegal.

The Justice Department investigation was initiated last summer when a number of physicians dropped out of the Medicaid program in response to the \$52 million

reduction in Medicaid reimbursement and in response to the 2% provider tax.

In a related investigation, the Justice Department also closed without action its investigation of some 50 physicians from Northern Kentucky who were accused of conspiring to withdraw from Medicaid.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Bell

Gwenyth Evenhouse, MD — OBG
3600 W Cumberland Ave,
Middlesboro 40965
1961, U of Queensland, Australia

Breathitt

Rogelio H. Delacruz, MD — PD
PO Box 169, Jackson 41339
1986, U of the Philippines

Daviess

Robert Keith Moore, MD — ORS
2816 Veach Rd, Owensboro 42303
1986, U of Kentucky

Franklin

Steven W. Crum, MD — FP
1001 Leawood Dr, Box 4168, Frankfort
40604
1992, U of Kentucky
Lawrence J. Sprecher, MD — IM
1 Physicians Park, Frankfort
40601-4107
1986, Indiana University

Jefferson

William M. Bailey, MD — IM
207 Sparks Ave Ste 104, Jeffersonville
47130
1985, Louisiana State U

Eric L. Berman, MD — OPH
100 E Liberty St Ste 800, Louisville
40202

1986, State U of New York at Brooklyn
Bradley C. Black, MD — OPH
1919 State St Ste 140, New Albany
47150

1977, Indiana U
Jyoti B. Burruss, MD — D
9703 Moorfield Cir, Louisville
40241-3022

1990, U of Louisville
David R. Corley, MD — OBG
39 Hallsdale Dr, Louisville 40220

1987, U of South Carolina, Columbia
Brennan P. Greene, MD — OPH
8008 Brookglen Ct, Louisville 40220
1991, U of Louisville

Thomas J. Lombardi, MD — R
1180 Mallard Creek Rd, Louisville
40207

1989, Wayne State U
Mary Nan S. Mallory, MD — EM
1530 Willow Creek Dr, Corydon 47112
1986, Marshall U

John C. Meyer, MD — OPH
100 E Liberty St Ste 800, Louisville
40202

1986, St. Louis U
Brian L. Moore, MD — P
2100 Gardiner Ln, Louisville 40205
1994, U of Kentucky

Alan J. Nissen, MD — OTO
6707 Wild Fox Ln, Prospect
40059-9479

1995, U of Nebraska
Jean M. Ogburn, MD — PD
3309 Thrush Rd, Louisville 40213
1990, U of Louisville

Antolin J. Perez, MD — AN
727 Hospital Dr, Shelbyville 40065
1991, U of Louisville

Melisa M. Pope, MD — PD
150 Long Run Rd, Louisville 40245
1990, U of Kentucky

Jason L. Port, MD — R
5612 Timber Creek Ct, Prospect 40059
1988, Mt. Sinai

Melinda G. Rowe, MD — PD
400 E Gray St, Louisville 40201
1978, Alabama

Aaron D. Stewart, MD — OBG
801 Barret Ave Ste 210, Louisville

40204

1991, U of Louisville

Northern Kentucky**David L. Gossage, MD** — A215 Thomas More Park Ste B,
Crestview Hills 41017

1986, U of Tennessee

Eric J. Lavonas, MD — EM

2932 Vista Ct, Villa Hills 41017

1992, State U of New York at Syracuse

Lincoln**Frederick J. Dressen, DO** — S

126 Portman Ave, Stanford 40484

1986, Chicago College of Osteopathy

Madison**Timothy E. Dineen, MD** — R

201 Layne Ct Apt A-3, Berea 40403

1989, U of Kentucky

Meade**Jawed M. Movania, MD** — IM302 Piping Rock Rd, Brandenburg
40108-9100

1990, Dow Medical College, Pakistan

Pike**Pankaj K. Bhatnagar, MD** — S804 Hambley Blvd Ste 1, Pikeville
41501-1372

1986, Maulana Azad, India

Taylor**John K. Garner, MD** — GP1856 Old Lebanon Rd, Campbellsville
42718

1988, U of Maryland

In-Training**Fayette County****Robert L. Kell, MD** — IM**Michael David Lauffenburger,**
MD — ORS**Jefferson County****Claudia M. Beck, MD** — PD**Annette R. Borger, MD** — IM**Brian D. Jones, MD** — P**Peter M. Steiner, MD** — P**Kathy M. Vincent, MD** — P**DEATHS****Alvin B. Ortner, MD****Louisville****1911-1996**

Alvin B. Ortner, MD, a retired general surgeon, died January 12, 1996. Dr Ortner was a 1937 graduate of the University of Louisville School of Medicine and a life member of KMA.

1996 KMA Practice Management Seminars

APRIL

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*If you would like more
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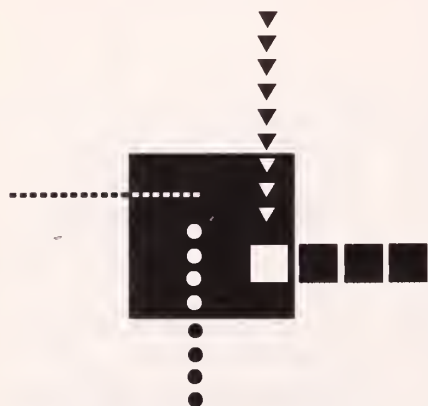
Organized Medical Staff Section

Twenty Seventh Assembly Meeting

June 20–June 24, 1996

Chicago Marriott Hotel

Chicago, IL



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Send a medical staff representative to the 1996 Annual American Medical Association Organized Medical Staff Section (AMA-OMSS) Assembly Meeting, June 20-24 in Chicago and have your voice heard. This meeting serves as a forum for discussing issues and crafting policies that impact our nation's health care as well as physician practice. Whether they be individual or collective interests centering on managed care, quality improvement, antitrust, medical ethics, due process, or peer review the OMSS wants your views and participation in helping to shape the future of medicine. The meeting also offers opportunities to network with colleagues and learn about new products and services from exhibitors.

Highlights of the June meeting include an information exchange, which builds on the December 1995, program theme, "Creating the Future and Getting There First." Physicians will:

- **Gain** insight into the "nuts and bolts" of establishing a viable, autonomous organization, and
- **Explore** various ways physicians can band together to become market leaders.

In addition, an education program, "Keys to Influencing Physician Performance and Developing Successful Clinical Pathways," will help physicians:

- **Master** outcomes measurement and management,
- **Differentiate** between outcomes measurements and clinical pathways, and
- **Understand** the success factors for developing clinical pathways.

Plan now to attend this stimulating and informative meeting. The Thursday evening Information Exchange and OMSS Educational Program on Friday afternoon are sure to provide information useful to your organized medical staff.

"The American Medical Association is accredited by the Accreditation Council for Continuing Medical Education to sponsor continuing medical education for physicians."

"The AMA designates this medical education activity for up to 3 credit hours in Category I of the Physician's Recognition Award."

For more information, please call 800 AMA-3211 and ask for the AMA's Department of Organized Medical Staff Services.

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If you are interested in designating an AMA OMSS representative and/or attending an upcoming meeting, call **800 AMA-3211** and ask for the AMA Department of Organized Medical Staff Services.

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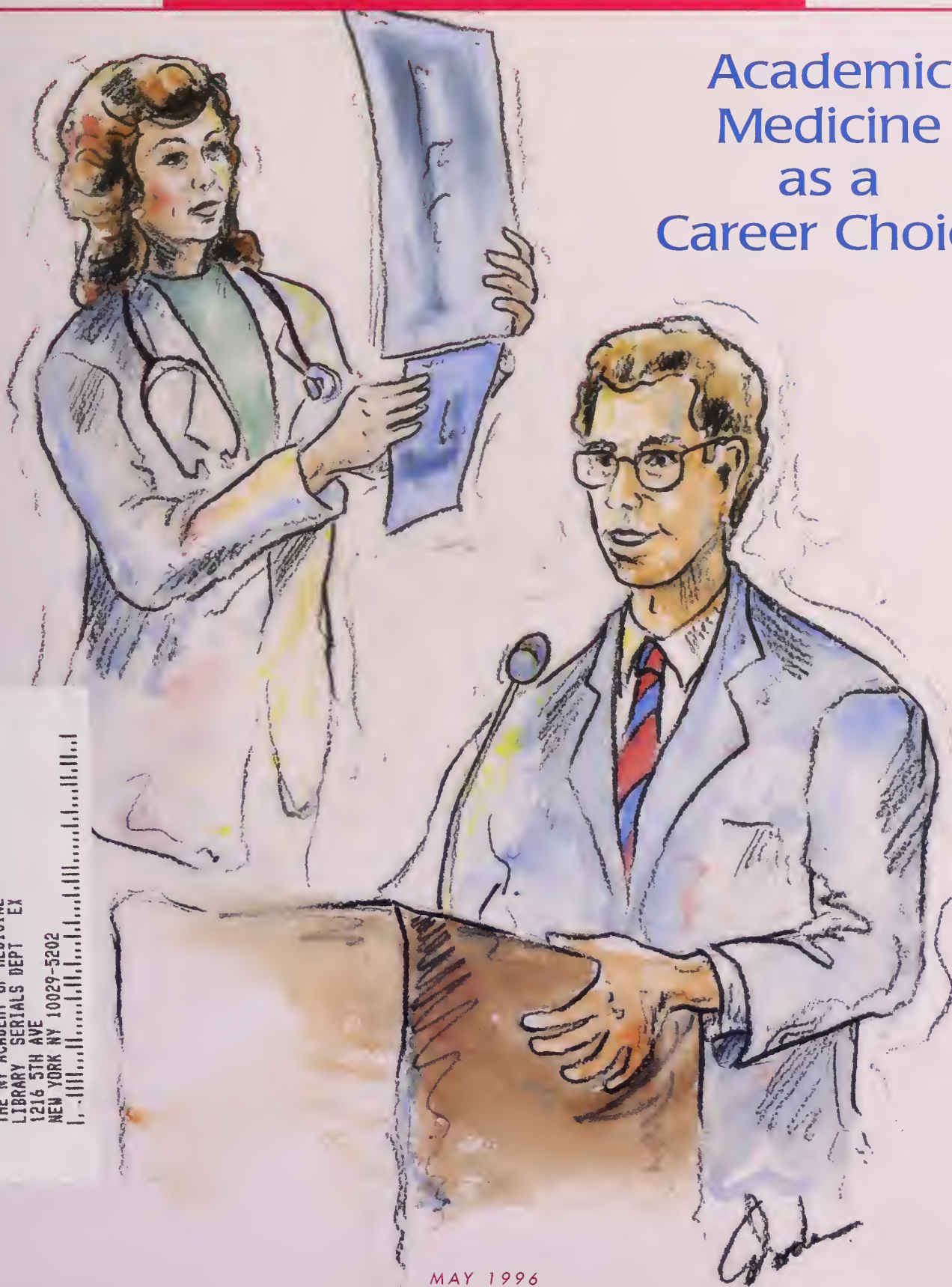
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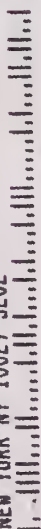
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MAY 1996

COVER STORY

- Factors Influencing Medical Students Choice of Academic Medicine as a Career **186**
*Michael B. Donnelly, PhD; Roy K. Jarecky, EdD;
Robert Rubeck, PhD; Amy Murphy-Spencer; Peggy Parr, PhD;
Richard W. Schwartz, MD*

SCIENTIFIC

- Presurgical Angiographic Localization of Small Bowel Bleeding Site with Methylene Blue Injection **192**
Jerome F. Schrodt, MD; William R. Bradford, MD

GRAND ROUNDS

- Identifying Communication Disorders in Children **197**
Lauren E. Bland, PhD

EDITORIAL

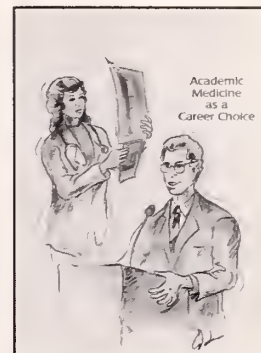
- Back to Basics **203**
Carolyn D. Burns, MD

ASSOCIATION

- Monitoring Medicine* **179**
1996 Legislative Session in Summary **179**
News **207**

DEPARTMENTS

- President's Page **177**
Advertisers' Guide **210**
Alliance Page **205**
Classifieds **209**
Information for Authors **195**



COVER: This month's cover story presents a study by the University of Kentucky College of Medicine and the Office of the Dean, to identify the characteristics of physicians who chose academic medicine as a career. See page 186.

Design and artwork by Lee Wade of Louisville.

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333 S Third St
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John W. McClellan, Jr, MD
1413 N Elm St
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1997

Thirteenth

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PO Box 1865
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1997

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1996

Tenth

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William H. Mitchell, MD

What Have You Done for Me Lately?

The 1995 Kentucky Medical Association (KMA) House of Delegates (HOD) established a formidable legislative agenda. The Board of Trustees, as directed, adopted a plan of action based on priorities. The legislative agenda undertaken by the Legislative Quick Action Committee (LQAC) in January dealt with three main areas of interest.

The first area of interest was the 2% Gross Revenue tax on Kentucky physicians. The 1995 HOD established repeal of the provider tax as a primary goal of the 1996 legislative program. The KMA HOD met on Sunday, March 3, 1996, in special session and reaffirmed and provided the LQAC latitude to support the Governor's proposal to progressively eliminate the tax on physicians.

The second area of interest was the repeal or significant modification of House Bill 250 (HB 250). The LQAC was directed to work toward the following:

1. Repeal the discount option program.
2. Repeal the practice parameter provisions.
3. Abolish or limit the powers of the Health Policy Board.
4. Alter or limit free medical records.
5. Limit and define data collection requirements.
6. Retain the Any Willing Provider provision.
7. Retain Provider Sponsored Network provisions.

The third area of interest in accordance with KMA HOD resolutions and reports directed the LQAC to work toward:

1. Restoration of Medicaid funding and restore reasonable reimbursement levels.
2. Establish a committee to work with the CHR secretary to find long range solutions to physician reimbursement and future delivery systems.
3. Settlement of the KMA/CHR lawsuit

relating to the \$52 Million Medicaid reimbursement cuts by the Jones Administration.

The LQAC worked closely with our lobbyists during the 1996 General Assembly. We established an excellent working relationship with Governor Paul Patton, Lieutenant Governor Steve Henry, and Cabinet Secretary John Morse. I am pleased to report to you that the KMA legislative leadership was able to successfully accomplish most of the items that were mandated by the HOD in our legislative agenda.

As a result of the KMA efforts in Frankfort, Governor Paul Patton on March 12, 1996, signed into law House Bill 397 — the repeal of the 2% Provider Tax. The tax will be reduced in increments of one-half percent over the next 3 calendar years, and effective August 1, 1999, physician gross revenues will no longer be subject to this taxation.

With regard to the second area of

interest, the General Assembly adopted Senate Bill 343. This Bill encompassed most of the revisions of House Bill 250 about which the KMA was concerned. Specifically, SB 343 did the following:

1. Abolished the Kentucky Health Policy Board, its powers and duties.
2. The Certificate of Need financial threshold triggering the requirement for a CON for major medical equipment is now equalized for physicians and hospitals at \$1,500,000.00
3. Repeals requirements that providers conspicuously post maximum fees charged for services.
4. Repeals the requirement that providers have the responsibility to provide written statements of charges to patients for services prior to rendering of care and disclosure of reimbursement to be paid.
5. Repeals the mandate to develop clinical practice parameters.
6. Limits prohibitions against provider self-referral to Medicaid and Medicare. The bill mandates that any conduct which violates Federal law relating to self-referral under Medicaid be deemed violation of state law.
7. Maintains the current law mandating that providers supply requesting patients one free copy of his or her medical record. It does, however, further authorize a copying fee of up to \$1.00 per page for a second copy when provided to the patient, patient's attorney, or authorized representative.
8. Grants associations (ie KMA)

exemption for exclusion of association health plans from the Alliance.

9. Prohibits insurer misrepresentation. An insurer or managed care network cannot imply or represent that a provider is part of a network unless authorized to do so by the provider.
10. Transfers data collection to the CHR but retains current law mandating collection of health costs and quality data from providers. However, data collection is limited to that information collected on the Uniform Health Insurance Claim form. SB 343 also creates a permanent advisory committee to define quality outcome measurements and advise the CHR on data interpretation and publication. However, we have some assurances that primary emphasis upon data collection will be placed on insurers.
11. Abolishes the Discount Option Program.
12. Retains insurance provisions supported by KMA including guaranteed renewability, portability, and limits on preexisting requirements.
13. Provider Sponsored Networks are retained, and solvency and other important provisions are clarified statutorily by codifying existing regulations into law.

Senate Bill 343, which was drafted by Governor Patton and Lt Governor Henry with significant input from KMA, accomplished the directives of the HOD.

We have been successful in establishing a blue ribbon panel of

physicians to work directly with Cabinet Secretary John Morse to develop a model for fair and equitable Medicaid reimbursements and to restore Medicaid funding to reasonable levels. That committee has had several meetings, and reports regarding the initial activities of this committee are favorable.

We are also in the process of settling the CHR lawsuit through an arrangement that should ensure adequate funding of the Medicaid program for the coming fiscal years.

As you can see, a great deal was accomplished by your Kentucky Medical Association during this General Assembly. We did not get everything that we wanted. The Provider Tax is still present, even though being progressively tapered. The activities of the Blue Ribbon Committee working with CHR require close attention in an attempt to develop a fair and equitable Medicaid fee schedule. The details of the provisions of the settlement of the KMA/CHR lawsuit will occupy much of our time in the near future. There is a great deal of work to be done. Fortunately, as a result of our efforts in Frankfort during the General Assembly, we have an excellent foundation upon which to plan future strategies. The constant awareness and political activity of our membership is more important now than it has ever been in the past. I urge you to stay politically active and to share your thoughts and concerns with KMA leadership and your individual legislators.

William H. Mitchell, MD
KMA President-Elect

MONITORING MEDICINE

NEWS FOR KENTUCKY PHYSICIANS

The 1996 Session in Summary

The 1996 Kentucky General Assembly completed its work on April 15. President-Elect William H. Mitchell, MD's article on the *Journal* President's Page outlines HB 397 (Provider Tax), SB 343 (Health System Reform), and other significant work done by KMA during the Session.

Members of the 1996 Kentucky General Assembly introduced 1633 bills, and KMA closely monitored 201, or 12%, of the total legislation introduced. Among the bills followed there were:

- 14 frontal attacks on managed care or HMOs
- 4 bills mandating specific health services under all insurance plans
- 15 adult/child/family violence legislative proposals
- 10 proposals to totally repeal or sharply alter HB 250
- 10 bills calling for repeal or phase out of the provider tax

The following legislation was introduced and either adopted or defeated in accordance with KMA policy:

- HB 186 — Maternity benefits are covered for a minimum of 48 hours/92 for caesarean. PASSED (KMA supports)
- HB 358 — Permits ARNPs to prescribe non-scheduled drugs under physician protocol. PASSED (KMA supports)
- HB 491 — Repeals various safety restrictions on the operation of all-terrain-vehicles. DEFEATED (KMA opposed)
- SB 139 — Restricts the purchase or sale of tobacco products to children. PASSED (KMA supports)
- SB 276/HB 476 — Repeals motorcycle helmet law. DEFEATED (KMA opposed)
- SB 400 — Requires the Commonwealth to fund the purchase of malpractice insurance for organizations and providers defined as "charitable health care providers." PASSED (KMA supports)
- SB 49 — Requires patients and providers to be notified of their right to appeal adverse determinations of private review agents to reduce or deny payment of health benefits. PASSED (KMA supports)
- HB 111 — Defines active TB and "isolates." Facilitates appropriate clinical services for recalcitrant or drug resistant patients. PASSED (KMA supports)
- HB 588 — Child immunizations — Establishes requirements prior to enrollment in school/day care centers, etc. PASSED (KMA supports)
- SB 139 — Permit children to file "loss of consortium actions" when parents are injured, etc. DEFEATED (KMA opposed)

The following bills were introduced, which KMA supported, but did not pass:

- HB 409 — Requires bicycle riders under age 14 to wear helmets.
- HB 85 — Restricts child operation of jet skis.
- SB 365 — KMA Patient Protection Act/Point of Service Option.
- SCR 110 — Studies the long-term care bed needs.
- HB 402 — Permit PAs to prescribe non-scheduled drugs.
- HB 81 — Disease prevention control.

Several proposals were adopted which KMA opposed:

- SB 212 — Permits optometrists to prescribe narcotics.
- HB 494 — Reimbursement of chiropractic services made "permissive" under Medicaid. Requires CHR to approve.
- HB 782 — Permits chiropractors to serve as "gatekeepers" for "covered services." Requires HMOs, etc, to cover optometric services.
- HB 309 — Mandates "one time" — "lifetime" domestic violence training course for primary care providers.

A summary of SB 343 is included with this article. If you would like a copy of any legislation, contact the Legislative Record Commission at 1-502/564-8100 and ask for the bill room. Minimal charges are required for copies and mailing costs.

The KMA gratefully acknowledges the support and assistance of Lt Governor Steve Henry, MD. In addition, physicians and patients of Kentucky were ably served by physician legislators Nick Kafoglis, MD, Bowling Green; Bob M. DeWeese, MD, Louisville; Jim Crase, MD, Somerset; and Ernie Fletcher, MD, Lexington. *KMA*

| Provision | Summary |
|-----------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Kentucky Health Policy Board | <ul style="list-style-type: none"> Abolishes Kentucky Health Policy Board. Transfers duties previously assigned to the board to various state agencies: <ul style="list-style-type: none"> Health data collection transferred to Cabinet for Human Resources; 24-hour health coverage pilot projects transferred to Department of Insurance; Certificate of need transferred to Cabinet for Human Resources; and Health insurance responsibilities transferred to the Department of Insurance. Prohibits restrictions from being placed on Health Policy Board member or employee's acceptance of employment or compensation from any facility or health care provider or from becoming a practicing health care provider within the State. |
| Health Cost and Quality Data Collection | <ul style="list-style-type: none"> Transfers data collection responsibilities from the Health Policy Board to the Cabinet for Human Resources. Retains current law mandating collection of health cost and quality data from providers, hospitals and health facilities. Limits mandated data submission to that collected on the uniform health insurance claim form under KRS 304.14-135. Creates permanent advisory committee to define quality outcome measurements and advise the Cabinet for Human Resources on data interpretation and publication. Repeals requirement that providers, hospitals, and health facilities conspicuously post maximum fees charged for services. Repeals right to written statement of provider's charge for services prior to rendering of service and disclosure of reimbursement to be paid. |
| Medical Records | <ul style="list-style-type: none"> Maintains current law mandating hospitals or providers to supply a requesting patient one free copy of his or her medical record. Authorizes a copying fee of up to \$1 for second copy of the medical record when provided to the patient or the patient's attorney or authorized representative. |
| Quality Improvement (Clinical Practice Parameters) | <ul style="list-style-type: none"> Repeals. |
| Twenty-Four Hour Insurance | <ul style="list-style-type: none"> Transfers authority for 24-hour health insurance coverage pilot projects from the Health Policy Board to Department of Insurance. |

| | |
|--------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Provider Self-Referral Restrictions | <ul style="list-style-type: none"> • Prohibitions against provider self-referral would be limited to Medicaid and Medicare funded cases. • Mandates any conduct which violates federal law relating to self-referral under Medicaid be deemed a violation of state law. |
| Certificate of Need (CON) | <ul style="list-style-type: none"> • Transfers administration of CON from the Health Policy Board back to the Cabinet for Human Resources. • Amends the definition of "health facility" to include facilities and services owned and operated by a health maintenance organization directly providing services. • Raises the expenditure threshold for major medical equipment from \$500,000 to \$1,500,000 before a CON is required for a physician's office. • Maintains current law requiring proposed projects to be in compliance with the State Health Plan. • Exempts long-term care projects exempted pursuant to Executive Order 96-129 from the requirement that they be completed within 36 months of receiving a Certificate of Need and provides that they be completed within specified timetables as of the effective date of Medicaid funding in the biennial budget. • Provides that ambulance services owned and operated by a city government, which propose to provide services in coterminous cities outside of the ambulance service's designated geographic service area, are not required to obtain a certificate of need if the governing body of the city in which the ambulance services are to be provided enters into an agreement with the ambulance service to provide services in the city which proposes to provide the service. |
| Health Purchasing Alliance | <ul style="list-style-type: none"> • To be attached for administrative purposes to the Department of Insurance but operated independently of the department. • Maintains as mandatory members state employees, local school district employees, and judicial department employees. • Grants voluntary membership to employees of state higher education institutions, local and county government employees, employers with 50 employees or less instead of current 100 employee groups, and to individuals. • Requires the Health Purchasing Alliance to certify the state employee self-insured plan (Kentucky Kare) as an accountable health plan as long as the plan operates in compliance with the statutes that created the self-funded plan. |
| Health Insurance Reforms | <ul style="list-style-type: none"> • Retains guaranteed renewability of health benefit plans. • Retains guaranteed-issue with a 12 month residency requirement. |

Health Insurance Reforms (Continued)

- Increases limitations imposed on coverage of pre-existing conditions in health insurance plans from 12 months instead of six months.
- Retains portability of health insurance coverage.
- Exempts student health insurance offered at colleges and universities from the health insurance reforms of 94 HB 250.
- Maintains modified community rating but permits the use of the following case characteristics:
 - Gender — no more than 50% variation from the lowest to highest rate factor;
 - Occupation — no more than 15% variation from the lowest to highest rate factor;
 - Allows discounts up to 10% for healthy lifestyles; and
 - For all case characteristics — no more than 5:1 variation from the highest to lowest rate factor.
- Exempts group plans issued prior to January 1, 1996, to one or more associations if the plan has been in continued existence from or before January 1, 1996.
- Permits phase-in of modified community premium rates as follows:
 - Until June 30, 1998, rates may deviate no more than 30% above or below the index community rate;
 - Beginning on July 1, 1998, the maximum permitted percentage deviation is 20%;
 - Beginning on July 1, 1999, the maximum permitted percentage deviation is 10%;
 - Beginning on July 1, 2000, no deviation is permitted.
- Prohibits requiring any individually insured person from replacing an individual policy with group coverage on becoming eligible for group coverage not provided by an employer.
- Requires all standard health benefit plans defined by KHPB to continue until Insurance Department amends or replaces. Allows Insurance Department to approve additional standard benefit plans as recommended by the Health Insurance Advisory Council.
- Creates the Health Insurance Advisory Council to advise the Commissioner.
- Allows any person covered by a health benefit plan on the effective date of the Act which is not a standard plan to renew the current coverage until the date 12 months after the effective date of the Act if the benefits remain exactly the same and the renewal is guaranteed.
- Requires the Commissioner of Insurance to review all health insurance rates filed between July 15, 1995, and the effective date of this Act and to order refunds where appropriate.
 - Authorizes the Commissioner to suspend an insurer's certificate of authority for at least one year for failure to comply with the commissioner's directive to issue refunds.
 - Directs the Commissioner to notify the Governor and the LRC when the review has been completed.

| | |
|---------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Health Insurance Reforms (Continued) | <ul style="list-style-type: none"> • Requires all rate filings to be on file for a 30 day waiting period before becoming effective. • Directs Insurance Commissioner to hold a hearing on every filing containing a premium increase greater than the percentage change in the medical care consumer price index. Specifies criteria to be considered by the Commissioner in approving or disapproving a filing. • Directs the Attorney General to participate in hearing as a health insurance consumer intervenor and allow persons designated by the Attorney General as health insurance consumer intervenors to have access to material evidence and information of the Department of Insurance relating to health insurance rate hearings as other parties to the hearing. • Authorizes the commissioner to withdraw previous approval of rates and order appropriate refunds. • Permits the continuation of group coverage for 18 months rather than nine months after a person terminates group membership and sets maximum conversion policy premium at 102% of group rate. • Retains the original "Any Willing Provider" language — KRS 304.17A-110(3) — from 94 HB 250. |
| Provider Networks | <ul style="list-style-type: none"> • Permits the creation of provider-sponsored networks and requires networks to obtain a certificate of filing from the Commissioner of Insurance. Sets forth the information to be provided to the Commissioner in a filing by a provider-sponsored network. Establishes financial solvency requirements for provider-sponsored networks. • Includes health benefit plans issued by a provider-sponsored network in the definition of a "health benefit plan" under KRS 304.17A-100. (This requires health benefit plans issued by a provider-sponsored network to comply with all insurance reforms.) |
| Kentucky Kare | <ul style="list-style-type: none"> • Requires the Health Purchasing Alliance to certify the state employee self-insured plan (Kentucky Kare) as an accountable health plan as long as the plan operates in compliance with the statutes that created the self-funded plan. • Amends KRS 18A.225 to provide that state health insurance policies for state employees shall not provide coverage for an abortion. |
| Medicaid | <ul style="list-style-type: none"> • Deletes the requirement that the Cabinet for Human Resources obtain federal waivers to impose a minimum \$3 copayment on specified Medicaid services. • Deletes the noninstitutionalized blind, aged, and disabled Medicaid recipients as mandatory participants in the KenPAC program. • Repeals the Discount Option Program. • Prohibits Medicaid payment for services provided in Kentucky by an out-of-state health facility or service if the facility or service who does not have a CON would otherwise be required to obtain a Certificate of Need if located in Kentucky. |
| Medical Education Reforms | <ul style="list-style-type: none"> • Repeals provisions of 94 HB 250 relating to medical education. |

TIMES HAVE CHANGED . . .

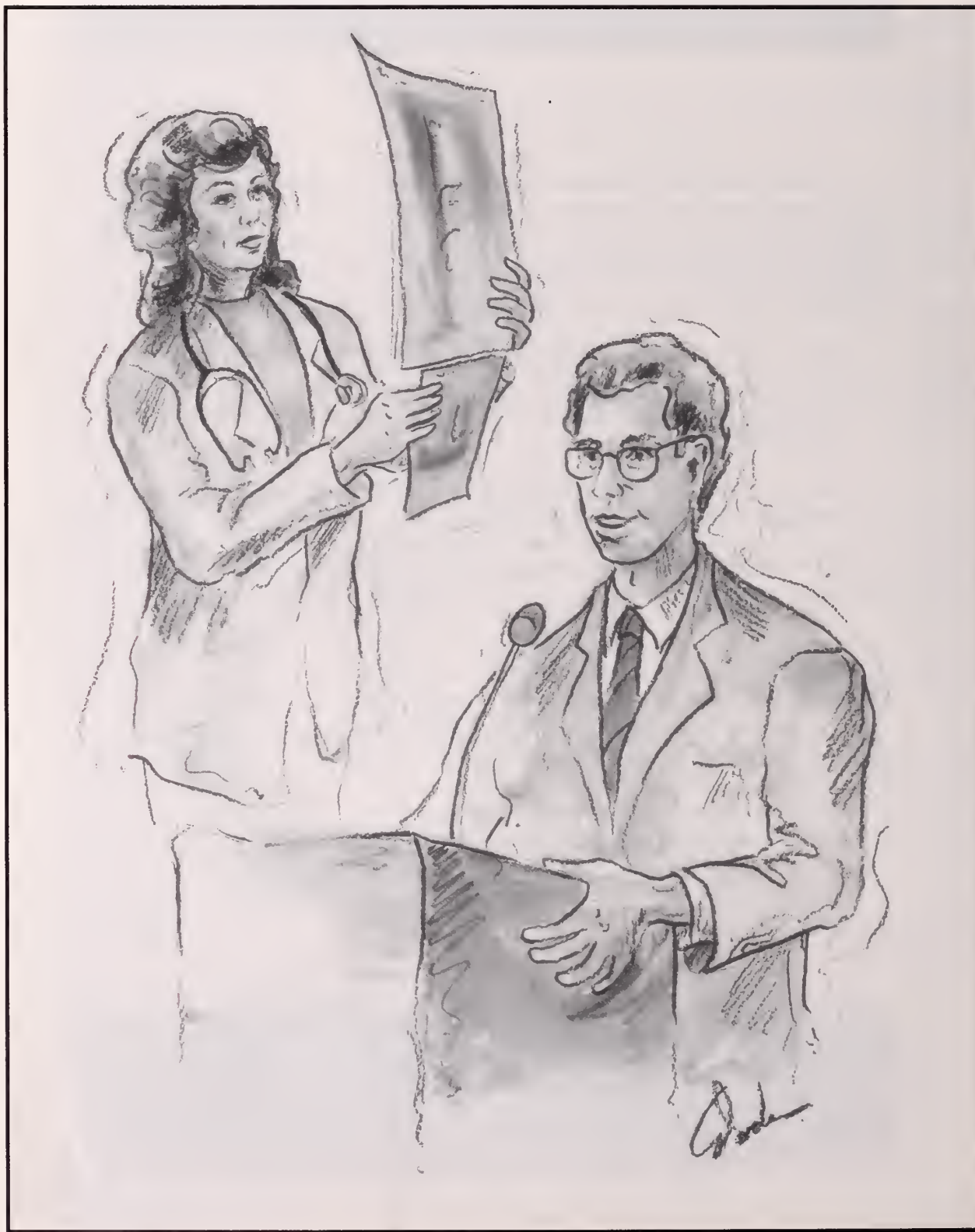
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Factors Influencing Medical Students' Choice of Academic Medicine as a Career

Michael B. Donnelly, PhD; Roy K. Jarecky, EdD; Robert Rubeck, PhD;
Amy Murphy-Spencer; Peggy Parr, PhD; Richard W. Schwartz, MD

The purpose of this study was to identify the characteristics of physicians who chose academic medicine as a career. A questionnaire was sent to all graduates of the University of Kentucky College of Medicine who held full-time positions in academic medical centers (n = 143). Ninety graduates (63%) returned usable questionnaires. Most of the physicians grew up in urban areas. Seventy-seven percent of the graduates entered academic medicine directly from their residency or fellowship programs. The most important factors cited by respondents as influencing a career choice of academic medicine were an interest in teaching and a belief that their personality and skills suited them to an academic environment. An interest in doing research was not a very important factor. Respondents also indicated why they chose their particular specialty. The two most important factors were the content of the specialty and intellectual stimulation. Most of these physicians (64%) were very satisfied with their careers in academic medicine.

In recent years, careers in academic medicine have not received the same level of support and interest as other medical careers such as primary care. However, because most medical schools are colleges within larger universities, academic productivity, as measured by such parameters as research programs, successful grant applications, and manuscript publication, continues to be an important goal. Most medical schools affiliated with large state universities are under pressure to increase their output in two seemingly divergent areas: educating primary care physicians, and increasing their academic productivity. If the latter goal is to be realized, a certain number of talented medical students must opt for careers in academic medicine (most of these will

be subspecialists). For this reason, it is useful to assess continually the effect of a medical college on the specialty selections and types of practice entered into by its graduates. The University of Kentucky College of Medicine (UKCM) has carefully tracked its graduates since the first class was graduated in 1964. The purpose of this study was to identify not only the characteristics of UKCM graduates who chose academic medicine as a career but also the factors that influenced this decision.

Method

A questionnaire was sent to the 143 UKCM graduates identified by the Association of American Medical Colleges (AAMC) as holding full-time positions in academic medical centers. Of the targeted group, 90 graduates (63%) responded with usable data. The questionnaire, distributed in March 1992, sought to secure information that provided a detailed description of each respondent's current occupational environment, a statement about when the decision to enter a career in academic medicine was made, and a listing of the factors that influenced this decision. Respondents were also asked to identify the type and size of the community in which they grew up and that in which they currently practice. The questionnaire probed the respondents' motivation for specialty selection and requested them to identify those individuals who influenced their choice of academic medicine as a career.

Results

Nineteen (21%) of the graduates who responded to the survey were women, 70 (78%) were men, and one did not identify gender. The women included 6 associate professors, 10 assistant profes-

From the Department of Surgery, University of Kentucky College of Medicine (Drs Donnelly and Schwartz), and the Office of the Dean, University of Kentucky College of Medicine (Drs Rubeck, Parr, and Jarecky, and Ms Murphy-Spencer), Lexington, KY, USA.

Academic Medicine as a Career

sors, 1 instructor, and 2 "other." Eight specialties were represented by women; internal medicine attracted the largest number of women academicians. Of the 70 men who responded, 24 were professors, 21 were associate professors, 24 were assistant professors, and 1 was an instructor. Fourteen specialties were represented by men; the largest subgroup was surgery, with 18 respondents. Ninety-nine percent of the members of the study group were board certified in their specialty choice. Of these board-certified physicians, 84% described themselves as having a research focus in clinical medicine. On average, 16% of their time was devoted to research, 21% to teaching, 19% to administrative duties, and 43% to clinical care.

Seventy-seven percent of those graduates who responded entered academic medicine directly from their residency or fellowship. The study participants were asked to rate on a five-point scale (0 = not a factor; 1 = a minor factor; 2 = an important factor; 3 = a major factor; and 4 = a critical factor) the influence of 19 factors on their career choice. The results of a repeated-measures analysis of variance comparing the relative importance of the factors were statistically

significant ($F = 41.61$; $df = 17$ and 1462 ; $p < .0001$). The Scheffé post hoc test indicated that the items could be grouped into four levels of importance. Table 1 presents both the mean rating and the level of importance for each item. The most important items were related to a desire to teach and a belief by the graduates that they would fit well into the academic environment. A desire to conduct research was, at best, a minor factor in the choice of a career in academic medicine; medical school research experience was the least influential factor.

Table 2 presents the time at which respondents made the decision to enter academic medicine. Interestingly, 74 of these physicians did not decide on an academic career until during or after their residency years. Although the medical school experience may have helped generate the possibility of an academic career, the actual decision to enter academic medicine appears to be a product of the graduate years.

The size of the communities in which the respondents grew up is presented in Table 3. As can be seen from the table, this sample of academicians tended to come from urban backgrounds; only one-third of the graduates in the sample were reared in towns with a population of 50,000 or less. As might be expected, 93% of the respondents now work in communities with populations of 50,000 or above; 63% are in communities with populations of 200,000 or above.

The academic physicians were also asked to rate the importance of 12 specific factors on their choice of specialty. These ratings were made on a five-point scale ranging from 0 (not important) to 4 (critically important). The results of a repeated-measures analysis of variance comparing the relative importance of the factors were significant ($F = 86.57$; $df = 11$ and 924 ; $p < .0001$). The Scheffé post hoc test indicated that the factors could be separated into four levels of importance. Table 4 presents the mean rating for each factor and its level of importance. As can be seen from this table, the selection of the current specialty was strongly determined by the content of the specialty and its intellectual stimulation; mentor role modeling and the opportunity for direct patient contact were also important factors in specialty selection, albeit less important than the first two. The other factors were not salient for choosing an academic career. Among these unimportant factors was "opportunity for participation in long-term research program." As noted earlier, research did not appear to be an important career

Table 1. Mean Importance Rating for Each Item In Influencing the Career Choice of Academic Medicine

| | | |
|------------------------------|---------------------------------------------------------------------------------------------|-------|
| <i>Least Important Items</i> | | |
| 13(4). | Extended fellowship during medical school | 0.276 |
| 13(5). | A particular medical school course and/or clerkship that emphasized research | 0.356 |
| 13(6). | An informal research and/or teaching experience during medical school | 0.425 |
| 13(10). | Family influence | 0.494 |
| 13(8). | An opportunity to publish research papers as a student | 0.506 |
| <i>Semi-Important Items</i> | | |
| 13(7). | A research environment fostered by the College of Medicine | 0.586 |
| 13(3). | Summer fellowship(s) during medical school | 0.632 |
| 13(2). | Research experience before medical school | 0.770 |
| 13(9). | A research experience subsequent to medical school | 1.103 |
| 13(17). | Felt competence as a researcher and that I could be a productive scientist | 1.126 |
| <i>Important Items</i> | | |
| 13(14). | A desire for professional recognition | 1.437 |
| 13(1). | A close relationship with a research mentor | 1.494 |
| 13(12). | Attractiveness of treating a highly specialized type of patient | 1.667 |
| 13(13). | Collegiality of academic setting | 1.885 |
| <i>Very Important Items</i> | | |
| 13(19). | Believe my personality and skills were such that I would be happiest in an academic setting | 2.540 |
| 13(11). | Interest in teaching medical students or residents | 2.586 |
| 13(18). | Wanted to teach | 2.632 |

choice factor for this group of academic physicians.

When asked whether they would make a totally different choice of specialty or career emphasis if they had it to do over again, only four of the respondents said that they would change their specialty; none said they would change their choice of academic medicine. Sixty percent of the respondents viewed the UKCM educational program as a positive influence on their decision to enter academic medicine; 79% identified specific faculty members as being of positive importance in their career choice. Finally, in terms of satisfaction with their role as academicians, 64% were "very satisfied," 25% of the group described themselves as "somewhat satisfied," 2% were "somewhat dissatisfied," and 2% were "very dissatisfied"; one person was uncertain.

Discussion

Past research into medical career choice has studied factors including student characteristics, curriculum format, school organization, and specialty attributes. In a study by Schraufnagel and Rezler,¹ students' choice of a career in academic medicine was associated with a personal desire for intellectual challenge, an opportunity to investigate, a desire for continued learning, and a potential for national recognition. Benson et al² have associated the choice of a career in academic medicine with the personal characteristics of living alone or being married to a professional.

However, it appears that the most important factor in choosing an academic career may well be the characteristics of the medical school. Several studies have investigated the relationship between school characteristics and career choice. One such study³ showed a positive relationship between a student's perception of the college as having a "research environment" and the likelihood of that student's entering an academic medical career. Hillman et al⁴ demonstrated a research status effect by finding that medical schools that are ranked among the top 20 of those receiving federal research funding are more likely to produce graduates choosing academic or research careers. Whitcomb et al⁵ showed that research intensity as measured by NIH funding was negatively associated with the production of primary care graduates.

Other studies have found an association between the presence of certain curricular requirements and the likelihood that graduates will

Table 2. Time When Decision Was Made to Enter Academic Medicine

| Time | Percent of Group |
|----------------------------------------------|------------------|
| Before entering medical school | 12 |
| During the first two years of medical school | 2 |
| During the last two years of medical school | 8 |
| During residency years | 31 |
| During fellowship years | 23 |
| Subsequent to residency and fellowship years | 20 |
| Other | 3 |

Table 3. Size of Communities In Which Academic Physicians Grew Up

| Size of Community (Population) | Percent of Group |
|------------------------------------------|------------------|
| Large city (500,000+) | 21 |
| Suburb of a large city | 13 |
| Medium-sized city (200,000-500,000) | 13 |
| Suburb of a medium-sized city | 1 |
| City of a moderate size (50,000-200,000) | 15 |
| Suburb of moderately sized city | 1 |
| Small city (10,000-50,000) | 11 |
| Town (2,500-10,000) | 11 |

Table 4. Factors Influencing Choice of Specialty

| | |
|---------------------------------------------------------------------|-------|
| <i>Least Important Item</i> | |
| 17(4). Threat of malpractice suits | 0.129 |
| <i>Semi-Important Items</i> | |
| 17(3). Anticipated salary | 0.847 |
| 17(2). Length, made, and stress of specialty training | 1.012 |
| 17(9). Presumed specialty prestige | 1.041 |
| 17(6). Time for leisure activities | 1.071 |
| 17(10). Control of hours worked | 1.165 |
| 17(12). Opportunity for participation in long-term research program | 1.247 |
| 17(7). Time for family activities | 1.329 |
| <i>Important Items</i> | |
| 17(5). Mentor role modeling | 2.329 |
| 17(8). Opportunity for direct patient contact | 2.624 |
| <i>Very Important Items</i> | |
| 17(11). Intellectual stimulation | 3.406 |
| 17(1). Content of specialty | 3.482 |

choose a related career path. At the Washington University School of Medicine,⁶ a curriculum emphasizing basic science has produced an impressive number of graduates committed to academic careers. Correlatively, two studies have found that the opportunity for students to be involved in research was associated with an increased likelihood of their choosing a research-related career.^{1,7} In addition, Schraufnagel and Rezler¹ have demonstrated that the existence of a student re-

Academic Medicine as a Career

search program sponsored by faculty and the concurrent opportunity for students to publish research findings were associated with an increase in the choice of a career in academic medicine.

A recent study by the AAMC indicates that, for the period of time from 1973 to 1983, 8.47% of UKCM graduates entered academic medicine. (From correspondence dated January 5, 1993, provided by Susan C. Sanderson, Research Associate, Section of Operational Studies, Association of American Medical Colleges, Washington, DC, USA.) During the same period, an average of 8.15% of the graduates of all US public medical schools (N = 74) selected careers in academic medicine. Interestingly, the UKCM percentage of 8.47 was secured without a strong focus on the development of research opportunities for students and with a major focus on primary care (roughly 60% of our graduates currently enter such specialties). The graduates responding to our survey, in contrast to the reasons for career choice cited in the literature, did not emphasize curriculum, research fellowship programs, or individualized electives as critical to their choice of academic medicine. Rather, their choice had to do with the opportunity to spend productive time with faculty members regardless of context. The findings did not, however, demonstrate that the decision to enter academic medicine was influenced by a small group of popular faculty members. Rather, the breadth of the group of mentors identified by the responders was truly astonishing. It appears that broad faculty contact is a factor in the choice of a career in academic medicine.


Two other factors identified by this study as leading to the choice of a career in academic medicine appear to be an urban rather than a rural background and the opportunity to teach. The fact that students from suburban or urban areas (population >50,000) select academic medicine is certainly not surprising, because most academic medical centers are in communities of such size. Sixty percent of those graduates re-

sponding to the survey viewed teaching as a very important professional experience that they wanted to pursue as academicians. The desire to teach reflects the importance of intellectual stimulation as a motivation for an academic career.

In summary, this study suggests that a college of medicine may produce appropriate numbers of both primary care and academic physicians by providing a curriculum that allows both formal and informal access to a broad spectrum of faculty members. By providing such a curriculum, medical colleges, especially those that are publicly funded, may fulfill two of their primary goals: producing an adequate number of primary care physicians, and promulgating quality research and teaching. The medical student who is intellectually oriented, wants to teach, is intrigued by problem solving, and comes from an urban environment may well, with appropriate role modeling by enthusiastic faculty, choose a career in academic medicine.

References

1. Schraufnagel DE, Rezler AG. Factors in the choice of academic or practice careers in pulmonary medicine. *Am Rev Respir Dis.* 1986;133:937-941.
2. Benson MC, Linn L, Ward N, Wells KB, Brook RH, Leake B. Career orientations of medical and pediatric residents. *Med Care.* 1985;23:1256-1264.
3. Haviland MG, Pincus HA, Dial TH. Career, research involvement, and research fellowship plans of potential psychiatrists. *Arch Gen Psych.* 1987;44:493-496.
4. Hillman BJ, Fajardo LL, Witzke DB, Cardenas D, Irion M, Fulginiti JV. Influences affecting radiologists' choices of academic or private practice careers. *Radiology.* 1990;174:561-564.
5. Whitcomb ME, Cullen TJ, Hart LG, Lishner DM, Rosenblatt RA. Comparing the characteristics of schools that produce high percentages and low percentages of primary care physicians. *Acad Med.* 1992;67:587-591.
6. Frieden C, Fox BJ. Career choices of graduates from Washington University's Medical Scientist Training Program. *Acad Med.* 1991;66:162-164.
7. Ferrier BM. Choosing a career within medicine: do the style and structure of medical schools make a difference? *Med Teach.* 1990;12:345-348.



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Presurgical Angiographic Localization of Small Bowel Bleeding Site with Methylene Blue Injection

Jerome F. Schrodt, MD; William R. Bradford, MD

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The source of gastrointestinal hemorrhage is found in 94-95% of patients who undergo radiologic and/or endoscopic examinations of the upper or lower bowel.¹ However, the exact presurgical localization of small bowel bleeding sites, which account for the other 5-6%, remains diagnostically difficult. We describe a previously reported and uncommon but useful angiographic technique used in conjunction with surgery which assists in this localization.

Case Report — A 73-year-old white female with a history of recurrent gastrointestinal bleeding over the last 20 years presented to the Emergency Department with a history of three separate melanic stools in the last 24 hours. Prior endoscopic and barium studies had never revealed an exact source of the bleeding and all previous episodes, including the most recent, 1 year prior, had been treated medically with good results. On admission, the patient's hemoglobin was 10.9 grams. A Nuclear Medicine tagged red blood cell scan revealed an abnormal collection of radiopharmaceutical in the distal small bowel and proximal right colon on a delayed, 14-hour image. A selective superior mesenteric arteriogram performed at this time revealed a 3.5 cm vascular tumor in the mid to distal jejunum with pooling of contrast in dilated venous channels (Fig 1). The tumor was supplied by a single branch from a mid jejunal artery and no active bleeding was noted at the time of the angiogram. The patient's condition remained stable and elective surgical resection was to be performed in 2 days. Immediately prior to surgery, a 5 French SIM2 catheter (Cook, Bloomington, IN) was placed from a femoral approach into the proximal part of the feeding jejunal artery. Through this

catheter was passed a 3 French Tracker catheter (Target Therapeutics, Freemont, CA) with the tip placed distally in the jejunal branch, just proximal to the vascular tumor (Fig 2). Both catheters were infused with saline and the patient was taken to the operating suite. Initial inspection of the opened abdominal cavity revealed no abnormal loops of small bowel. Three cc's of 1% methylene blue were then injected into the smaller, more distally placed catheter, and a significant bluish stain was noted in a single loop of small bowel located in the pelvis (Fig 3). Closer inspection of this loop revealed the presence of a submucosal tumor which was adherent to the right fallopian tube. The tumor was mobilized and the involved segment of bowel (20 cms) resected. Frozen section and final microscopic diagnoses showed a stromal tumor consistent with a leiomyoma with an area of central necrosis. The patient's postoperative course was uneventful.

Discussion

The primary diagnostic procedure in patients with massive upper or lower gastrointestinal hemorrhage should be endoscopy.² The site and cause of the bleeding can often be identified with this procedure alone, leading to an appropriate therapeutic decision.

Radionuclide imaging also plays an important role in gastrointestinal hemorrhage. Of the two types of studies currently employed, ^{99m}Tc-sulfur colloid and ^{99m}Tc-labeled red blood cells, the latter is more generally used because the labeled cells remain in the intravascular space for several hours, allowing for repeat and delayed images.³

When both endoscopy and radionuclide imaging fail to accurately localize the site of bleed-



Fig 1 — Selective superior mesenteric arteriogram shows a well circumscribed 3.5 cm hypervascular small bowel mass (arrow) with pooling of contrast in dilated venous channels.



Fig 2 — Superselective mesenteric digital arteriogram performed immediately prior to surgery again reveals the hypervascular mass. Note tip of 3 French peripherally placed catheter (arrow).

ing, angiography can be employed as both a diagnostic tool as well as a form of therapeutic intervention.² The general angiographic appearance of acute gastrointestinal bleeding is extravasation of contrast medium at the bleeding site. Frequently, however, at the time of angiography, contrast extravasation is not demonstrable. In these situations, the presence of varices, dilated feeding arteries, pooling of contrast in dilated venous channels, and early draining veins can sometimes be found as indirect signs as to the cause of bleeding.²

Gastrointestinal hemorrhage can be acute and massive or chronic and intermittent. Causes of acute upper gastrointestinal bleeding include ulcer disease, gastritis, esophageal varices, and



Fig 3 — Intraoperative photograph shows bluish stained loop of small bowel prior to resection.

Angiographic Localization of Small Bowel Bleeding Site

Mallory-Weiss Syndrome.⁴ In the lower GI tract, (distal to the ligament of Treitz), causes include bleeding colonic diverticula, tumors, and angiodysplasia.^{2,4} The accurate localization of the bleeding site prior to surgery is necessary to allow for conservative resection of the portion of the bowel containing the lesion. This precise localization is more difficult in the small bowel than in the colon, where the bowel is fixed and the site of bleeding predicted by the location on the arteriogram. It is in the small bowel, therefore, that presurgical arteriographic localization plays a major role.

Arteriovenous malformations are thought to be the most common cause of chronic, recurrent bleeding from the small bowel. In two series of patients evaluated for obscure gastrointestinal blood loss, arteriovenous malformations accounted for approximately 80% of the small bowel lesions.^{1,5} Other causes of small bowel bleeding include tumors, such as leiomyomas and adenocarcinomas, diverticuli (Meckel's), ulcers, and inflammatory bowel disease.⁶ Localization of small bowel arteriovenous malformations have previously included intraoperative angiography with placement of metallic clips,⁷ transillumination of bowel, palpation, and preoperative mesenteric methylene blue dye injection.⁸ In the case study presented here, we have utilized superselective preoperative mesenteric angiography with methylene blue to localize a hypervascular small bowel submucosal tumor which was not readily apparent upon initial inspection of the bowel at surgery. The innermost catheter was not injected until the bowel was surgically exposed for fear that the bluish staining would only last a very short time. It should be noted that the involved segment of small bowel, including the mesentery, remained stained for the entire length of the operation, including the extra time needed to mobilize the tumor from the fallopian tube. We feel, therefore, that in some instances, the methylene blue can be injected in the angiography suite and the catheters completely removed prior to the patient being transported to surgery.

Methylene Blue (tetramethylthionine chloride) is a commonly used marking agent in plastic and reconstructive surgery. It is occasionally applied to the adventitial surface to provide orientation and thereby prevent torsion during microsurgical procedures.⁹ In addition, methylene blue is an irreversible inhibitor of the action of endothelium-derived relaxing factor through a yet undefined mechanism on the enzyme guanylate cy-

clase.¹⁰ The use of methylene blue to mark blood vessels can, therefore, promote vasospasm, platelet adhesion and platelet aggregation, and damage vessels during microvascular surgery.

Methylene blue is frequently used during radiologically guided breast-needle localization procedures to stain the area of interest prior to surgical excision. In tissues, the dye is reduced to a leuko (colorless) form and is excreted slowly in the bile and urine. When given intravascularly, methylene blue stains tissues a deep blue. Large doses (500 mgs) can cause nausea, abdominal and precordial pain, mental confusion, and methemoglobinemia.¹¹ Interestingly, lower intravenous doses of methylene blue (1-2 mg/kg) are used in treatment for acute, drug-induced methemoglobinemia. In addition, hemolysis and anemia secondary to erythrocyte destruction has been reported in patients receiving the dye who suffer from glucose-6-phosphate dehydrogenase deficiency.¹¹

In summary, angiography is a useful adjunct in the workup of patients with gastrointestinal hemorrhage in whom endoscopy, radionuclide, and barium imaging fail to accurately localize the site of bleeding. In addition, presurgical, superselective mesenteric angiography with intraoperative methylene blue dye injection is of particular value for hypervascular and/or actively bleeding small bowel lesions to precisely localize the site and therefore minimize the amount of bowel resected.

References

1. Lewis BS, Wayne JD. Chronic gastrointestinal bleeding of obscure origin: role of small bowel enteroscopy. *Gastroenterology*. 1988;84:1117-1120.
2. Reuter SR, Redman HC, Cho KJ. Gastrointestinal bleeding. In: *Gastrointestinal Angiography*. Philadelphia: Saunders, 1986:282-308.
3. Walker JM, Margoulef D. Scintigraphy of gastrointestinal hemorrhage. In: *A Clinical Manual of Nuclear Medicine*. Norwalk, Connecticut: Appleton-Century-Crofts, 1984:273-277.
4. Kadir S. Visceral angiography. In: *Diagnostic Angiography*. Philadelphia: Saunders, 1986:360-370.
5. Foutch PG, Sawyer R, Sanowski RA. Push enteroscopy for diagnosis of patients with gastrointestinal bleeding of obscure origin. *Gastrointest Endosc*. 1990;36:337-341.
6. Herlinger H, Maglinte DDT. Tumors of the small intestine. In: *Clinical Radiology of the Small Intestine*. Philadelphia: Saunders, 1989:402-403.
7. Hines JR, Stryker SJ, et al. Intraoperative angiography in intestinal angiodysplasia. *Surg Gynecol Obstet*. 1981;152:453-459.
8. Athanasoulis CA, Moncure AC, Greenfield AJ, et al. Intraoperative localization of small bowel bleeding sites with com-

bined use of angiographic methods and methylene blue injection. *Surgery*. 1980;87:77-84.

9. Bentz ML, Sheppeck RA, Macpherson T, et al. Vasospasm and Platelet Deposition in Human Arteries: Effects of Topical Methylene Blue. *Plast Reconstr Surg*. 1991 Nov;88(5):851-859.

10. Johnstone MT, Lam JYT, Lacoste L, et al. Methylene blue inhibits the antithrombotic effect of nitroglycerin. *J Am Coll Cardiol*. 1993 Jan;21(1):255-259.

11. Gilman AG, Goodman LS, Gilman A. Dyes. In: *The Pharmacological Basis of Therapeutics*. New York: Macmillan, 1980:980.

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Identifying Communication Disorders in Children

Lauren E. Bland, PhD

Pediatricians, general practitioners, and family practice specialists will most likely be among the first to recognize a deficit in communication skills, especially in children. The purpose of this article is to describe communication disorders in children and provide some direction as to when to refer patients for speech or language assessment.

The terms language, speech, and communication are often used interchangeably. While they are indeed interrelated, they are different conceptually.

- *Language* is a shared code for representing concepts with arbitrary symbols and rule-governed combinations of those symbols.¹ A primary feature of language is that it is learned. Human beings have to be exposed to language before they may become competent in using it.
- *Speech*, a medium through which language is expressed, is a series of mutually agreed upon vocal symbols. While speech is not essential in all settings, it is the most widely used medium for language. Other mediums include American sign language (ASL) or alternative/augmentative communication (AAC).
- *Communication* is an active process of sharing thoughts, ideas, attitudes, feelings, and desires,¹ generally through language and speech.

In addition, the American Speech-Language-Hearing Association (ASHA) has published guidelines for defining communication, language, and speech disorders.² A communication disorder is an impairment in the ability to receive, send, process, and comprehend concepts of verbal, non-verbal, and graphic symbol systems, which may be evident in the processes of hearing, language, and/or speech. Language disorders may impair comprehension or expression of oral or written language, while a speech disorder impairs articulation, fluency, or voice. Speech-language pathologists or audiologists, who work with children

with communication disorders, are licensed by the state of Kentucky and hold certification from ASHA.

Communication Disorders

Prevalence

It is generally estimated that 10% of the population in the United States has a communication disorder. While there are limited data indicating the exact number of residents with a communication disorder in Kentucky, there are data revealing the number of residents with disabilities that may cause communication disorders. Table 1 describes these selected disabilities and their prevalence in Kentucky.

Risk Factors

Communication disorders may or may not be secondary to other conditions. Billeaud³ suggested that infants and toddlers at risk for communication disorders can be placed into three relatively distinct groups.

The first group is children with obvious handicapping conditions that are known to affect communication, such as cerebral palsy or Down syndrome. These children may present with resonance disorders or with motor speech difficulties, such as dysarthria, apraxia, or phonologi-

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Table 1. Kentuckians with Selected Disabilities

| Disability | Prevalence (%)* |
|------------------------------|-----------------|
| Learning disability | 3.9 |
| Brain or neurological damage | 1.4 |
| Mental retardation | 1.2 |
| Cerebral palsy | 1.0 |
| Stroke | 0.5 |

Source: Kentucky Statewide Study of Persons with Disabilities, Kentucky Department of Education, Office of Vocational Rehabilitation, Frankfort, KY.

* Ages birth through 15 years.

Communication Disorders in Children

cal impairment. In some patients, acquisition of language may be impaired or delayed. In others, alternative or augmentative communication systems may be considered. For example, children with exposure to teratogens (fetal alcohol syndrome, cocaine, etc) should have early and ongoing evaluation of their communicative development.

The second group cited by Billeaud³ includes children at medical or biological risk for conditions affecting communicative development. This might include a confirmed family history for specific disorders, such as learning disability, atypical neurobehavioral function in infancy that could lead to feeding or swallowing problems, and such environmental risk factors as maternal age (very young) or strong family history of abuse or neglect. Children in this group should have their communicative status monitored and assessed as needed.

In the third group, Billeaud³ categorized children at significant risk for atypical communicative development based on cumulative factors. This would include any combination of the biological, medical, or environmental factors already described, as well as any acquired disease, injury, or condition. Children in this group may need an evaluation of their communicative status, with follow-up and treatment, until the condition is resolved. Other children may need ongoing treatment, or at least monitoring of their communication skills.

A major cause of communication disorders in children is hearing impairment, both conductive or sensorineural. Children with hearing impairments, even fluctuating conductive losses from otitis media (OM), may comprise a large part of a physician's practice. It is obvious that in order for a child to develop adequate speech and language, there must be an auditory signal. When that auditory signal is interrupted or impaired, speech and language will be affected.

All professionals involved with children must be aware of even subtle changes in auditory acuity. Technological advances enable audiologists to make some determination about an infant's auditory skills from birth. In 1982, the Joint Committee of Infant Hearing of the American Academy of Pediatrics⁴ recommended screening of all newborns for hearing loss. Many hospitals regularly conduct well-baby hearing screenings in neonatal units. It is crucial to understand that an infant's auditory skills can be assessed at any age, and it is never too early to refer an infant for

audiological assessment.

The ASHA Joint Committee on Infant Hearing⁵ issued a position statement in 1990 on the early detection of hearing impairment, establishing criteria to identify infants at risk for sensorineural hearing impairment. One criterion is a family history of childhood hearing impairment. To obtain this information, an adequate case history should be obtained, with care taken not to dismiss any expressed concern from the family of a relative who has had a hearing impairment as a child. The risk factors are not as great if the family member developed a hearing impairment due to trauma in adulthood or presbycusis.

Another criterion is the presence of anatomic malformations involving the head or neck. It has been well-documented that craniofacial syndromes, such as Waardenburg's or Treacher-Collins, are frequently associated with hearing impairment. In addition to noting any syndromes, the pinna or ear canal will need to be inspected for abnormalities. This involves a careful visual inspection and a careful review of the birth history.

Other risk factors include congenital perinatal infection (eg, cytomegalovirus, herpes, toxoplasmosis, syphilis), birthweight less than 1500 g, hyperbilirubinemia at levels exceeding indication for exchange transfusion, bacterial meningitis, severe asphyxia, or prolonged mechanical ventilation. Hearing should also be screened in the event of head trauma, incidents of childhood infectious diseases, or the detection of neurodegenerative disorders, such as neurofibromatosis, infantile demyelinating neuropathy, or myoclonic epilepsy.⁵

Even in the absence of these criteria, a hearing loss may still be present and first noted by those most involved with the child. Parents often experience frustration at not being taken seriously when they believe that their child is not hearing adequately. Results of a recent study⁶ indicate that the average interval between parental suspicion and the diagnosis of mild-to-moderate hearing loss is approximately 7 months, and another 6 months before children are fitted with some type of amplification. This means that in many cases, a year may pass from the time a parent suspects something is wrong. Based on this study, the concerns of the parent or caregiver should not be overlooked or dismissed.

Screening Procedures

Because of the strong link between hearing and

the development of adequate communication skills, it is crucial that any hearing loss be identified as early as possible. Hearing must be sufficient during the first years of life, when a child is learning to discriminate sounds, experiment with their vocal skills, or interact with a family unit.

It is not always possible to screen a newborn infant's hearing before he or she is discharged from the hospital. In this circumstance, it is suggested that some informal procedures be completed in an office or home visit. Before undertaking these procedures, it is important to note that these are behavioral observations. While they can be considered reliable, to some degree, it should be noted that these procedures are conducted in an attempt to observe a behavior or absence of a behavior. Caution is necessary when deciding that the perception of an expected behavior indicates normal hearing.

One of the most common methods to informally assess hearing is to elicit a startle response by producing a loud noise out of the infant's line of vision. The noise should not be so loud as to create a vibration, which might cause the baby to start, giving the appearance of hearing. It is helpful to discuss with the parents how the infant responds to common household noises, such as a vacuum cleaner or garbage disposal, and to inquire about sleep patterns. Is the baby easily awakened by noise?

As the baby grows and develops more head and neck control, localization for sound should be observed. Again, this is assessed out of the child's line of vision. When the child is alert, produce sound from several directions and note whether the child searches for the source (Fig 1). The response of the child will vary greatly, especially with the age of the child. Some children may turn their heads toward the sound, while others may search only with their eyes. Others may become quiet, others agitated. Whenever the response is in doubt, a complete audiological evaluation should be considered.

A major contributing factor to the successful treatment of a communication impairment is early identification. Rosetti⁷ suggested that interference with a child's ability to interact with the environment normally can contribute to developmental delay.

The impact of OM and otitis media with effusion (OME) on communication continues to be a much-discussed issue. Before the age of 6, 90% of American children will experience at least one ear infection⁸ during their critical language devel-

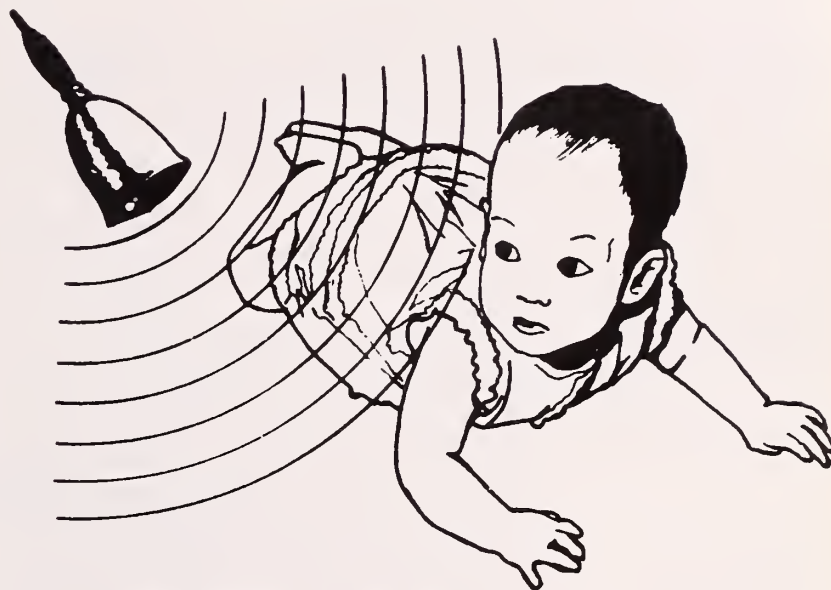


Fig 1 — Does the child search for the source of sound that is produced out of the infant's line of vision? If no response is elicited from the child, a complete audiological evaluation is suggested. (Reprinted with permission from Swigart ET, ed. Neonatal hearing screening. San Diego, CA: College-Hill Press, 1986.)

opment years. Professionals treating these children are still attempting to confirm the impact of childhood ear infections on language. Northern and Downs⁸ cited several studies supporting the notion that persistent OM does not impact communication development, because the hearing loss is slight and of relatively short duration. They further cited studies suggesting that there is a negative impact on speech and language due to the presence of an inconsistent auditory signal during a crucial time of development. This indicates causal relationship between OM and language.

The Joint Committee on Infant Hearing of the American Academy of Pediatrics issued a policy statement in 1982 regarding the relationship between OM, OME, and language. A parent or other caretaker may be the first person to detect such early symptoms as irritability, decreased responsiveness, and disturbed sleep. When a child has frequently recurring acute OM and/or middle ear effusion persisting for longer than 3 months, hearing should be assessed and the development of communicative skills monitored.

The committee stated that it is important for physicians to inform parents that a child with middle ear disease may not hear normally. Any parent who expresses concern about a child's hear-

Communication Disorders in Children

Table 2. Speech and Language Milestones

| Age Group | Questions |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Birth to 6 months | <p>Does the baby make sounds other than crying?</p> <p>Does the baby make sounds in response to caregiver presence?</p> <p>Does the baby appear to play with sounds or vocalizations?</p> <p>Is it possible to differentiate the baby's cries?</p> <p>Does the baby respond to voices, familiar and unfamiliar?</p> <p>Has the baby begun to make sounds like vowels, or the consonants p or k?</p> <p>Does the baby suck or swallow without difficulty?</p> |
| 7 months to 1 year | <p>Is the baby beginning to recognize its name?</p> <p>Does the baby appear to recognize "no"?</p> <p>Does the baby appear to use sounds to gain attention?</p> <p>Is the baby making a variety of sounds?</p> <p>Does the baby repeat consonant-vowel combinations like "ba-ba-ba" and later on, "bakatu"?</p> <p>Toward the end of the first year, does the baby appear to use the same sound pattern as if it were a word?</p> <p>Toward the end of the first year, is the baby able to follow simple commands, like "Come here," "Wave bye-bye"?</p> |
| 1 year to 2 years | <p>Does the child recognize one or two body parts?</p> <p>Does the child recognize favorite toys or familiar objects?</p> <p>Can the child point to pictures in a simple book?</p> <p>Does the child appear to be saying new words every month?</p> <p>Has the child started to put two words together?</p> <p>Does the child make verbal requests?</p> <p>Does the child speak with adult-like intonation and rhythm?</p> |
| 2 to 3 years | <p>Does the child seem to understand opposites (stop vs. go)?</p> <p>Does the child listen to short, simple stories?</p> <p>Does the child demonstrate common use of toys like pushing a car or feeding a doll?</p> <p>Does the child ask questions?</p> <p>Does the child initiate conversation?</p> <p>Does the child speak, using 2 or 3 words at a time?</p> <p>Do the primary caregivers understand most of what is said?</p> |
| 3 to 4 years | <p>Can the child answer "who, what, or where" questions?</p> <p>Does the child recognize sex difference pronouns?</p> <p>Does the child speak, using 3 or 4 words at a time?</p> <p>Can the child carry on long conversations?</p> <p>Can an unfamiliar listener understand most of what the child said?</p> <p>Does the child talk about remote events?</p> <p>Does the child ask numerous questions?</p> |
| 4 to 5 years | <p>Does the child understand at least 1500 words?</p> <p>Can the child completely follow 2- or 3-part directions?</p> <p>Does the child ask questions after hearing a simple story?</p> <p>Are most of the child's sentences about 4 words in length?</p> <p>Has the child begun to use descriptive words in sentences?</p> <p>Can the child tell a simple story?</p> <p>Are most speech sounds produced correctly?</p> |

ing should be referred for behavioral audiometry.

The series of questions posed in Table 2 are designed to assess communication delays in the preschool population. These questions may be answered by the caregiver or by direct observation. If, at any age, the answers to most of these questions are "no," that child may be at risk for developing impaired communication. Children in different developmental stages may appear to have a speech disorder. For example, many children appear to stutter between the ages of 3 and 4, when they are beginning to experiment more with language, and may have some difficulty expressing their thoughts.

Resources

First Steps is a system of coordinated service delivery for children in Kentucky who present with developmental delays. Such services include nursing, nutrition, audiology, or speech-language pathology. Referrals to First Steps can be made by anyone (ie, physician, nurse, therapist, member of child's family) who is familiar with a child in need of early intervention.

A selected group of published screening resources are shown in Table 3, and several other organizations that provide both professional and consumer support are listed in Table 4.

Summary

Development of communication skills is an essential component of human growth. The ability to express oneself is crucial for social, emotional, educational, and vocational success in society. A popular theory of language development suggests that humans are social creatures who crave contact with one another. In view of this need to communicate and interact, it is apparent that people without adequate communication skills may face obstacles in many areas of life.

As children grow and develop, there is an expectation that they will learn to talk. Numerous factors, from hearing loss to developmental delays, contribute to communication impairment. When the expectation of normal speech and language is not met, social and emotional problems can result, in addition to the communication disorder. Many problems secondary to communica-

Table 3. Selected Group of Published Screening Resources

| Publication | Source |
|----------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Clinical Linguistic and Auditory Milestone Scale (CLAMS) | Capute AJ, Accardo PJ. Linguistic and auditory milestones during the first two years of life: a language inventory for the practitioner. <i>Clinical Pediatrics</i> . 1978;17:847-853. |
| Developmental Profile | Alpern GD, Boll TJ, eds. Developmental profile: manual. Aspen, CO: Psychological Development Corporation, 1972. |
| Learning Accomplishment Profile for Infants (Early LAP) | Griffin PM, Sonford AR, eds. <i>Learning accomplishment profile for infants</i> . Winston-Salem, NC: Kaplan Press, 1978. |

Table 4. Organizational Resources

| |
|-----------------------------------------------------|
| American Speech-Language-Hearing Association (ASHA) |
| Autism Society of America |
| Kentucky Speech-Language-Hearing Association |
| Learning Disabilities Association of Kentucky |
| Self Help for Hard of Hearing (SHHH) |
| Speech Foundation of America |

tion disorders, such as isolation, ridicule, and academic failure, can be prevented with early identification and intervention.

References

- Owens RE. *Language development: an introduction*. 4th ed. Boston: Allyn and Bacon, 1996.
- American Speech-Language-Hearing Association. Definitions of communication disorders and variations. *ASHA*. 1993;35(Suppl 10):40-41.
- Billeaud FP. *Communication disorders in infants and toddlers: assessment and intervention*. Boston: Andover Medical Publishers, 1993.
- Joint Committee of Infant Hearing Position Statement. American Academy of Pediatrics. *Pediatrics*. 1982;70:496-497.
- Joint Committee on Infant Hearing 1990 position statement. *ASHA*. 1991;33(Suppl 5):3-6.
- Harrison M, Roush J. Age of suspicion, identification, and intervention for infants and young children with hearing loss. *Ear Hear*. 1996;17:55-62.
- Rosetti L. *High risk infants: identification, assessment and intervention*. Boston: College Hill Press, 1986.
- Northern JL, Downs MP. *Hearing in children*. 4th ed. Baltimore: Williams and Wilkins, 1991.

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Back to Basics

"It takes so little time and so little effort on our part to provide this product. . . . One hour of time can provide numerous components for your patients, and perhaps even your loved ones."

I doubt that any of us could deny that we are often baffled by the strides and changes that our profession has seen within the past decade. We are barraged daily with high tech equipment, pharmaceutical innovations and information systems, all of which are touted as a necessity if we want the best in patient care.

Amidst these ever-pressing changes, there is still one simple therapeutic that we all use and very likely take for granted. This product is blood and its components. Transfusion therapy in some form has been a part of our armamentarium for decades.

Toward the end of 1995 we experienced a regional and national blood crisis. There were shortages of various components across the country. In our blood bank, we have learned to anticipate this, particularly during the holiday season when needs are increased. Often, however, we have similar shortages throughout the year. I am frequently met by exasperated physicians, nurses, and students when we ask that resources be reallocated or transfused in often fairly "creative" ways. It dawned on me that blood products are a commodity that everyone expects to have available at all times.

But . . . the simple truth is, the reality is we only have enough if it is given, ie, donated. During our holiday crisis I was asked by the head of nursing in the OR what she could do to help. I very simply answered "Go down two blocks to the Red Cross and donate." And do you know that

within 2 to 3 hours there were several of her staff present for either whole blood donation or platelet pheresis. What a gift!

It takes so little time and so little effort on our part to provide this

"Amidst these ever-pressing changes, there is still one simple therapeutic that we all use and very likely take for granted. This product is blood and its components."

product. The phlebotomy causes minimal pain, you have the opportunity to lie down and rest (which few of us ever do), and you mustn't forget the snacks! One hour of time can provide numerous components for your patients, and perhaps even your loved ones.

Against the back-drop of increasingly complex procedures, equipment, informatics, and medications, we often forget one of the basic therapeutic interventions available for our patients — blood. Donate your time, donate blood.

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The Bumble Bee CAN Fly



Ruth Ryan

Biologists have determined that, technically speaking, the bumble bee cannot fly. Fortunately, the bumble bee does not believe the biologists. Similarly, members of the Alliance do not impose limitations on themselves. Seventy-three years ago, at Crab Orchard, Kentucky, 25 women met to form an Auxiliary to the Kentucky Medical Association, under the supervision of Dr Arthur T. McCormack, secretary, and Dr Louis Frank, retiring president of the Kentucky Medical Association.

Mrs Graham Lawrence of Shelbyville was elected the first Auxiliary president. Berea students carved a gavel from wood taken from a crab apple tree in Crab Orchard Springs. That gavel was retired 25 years ago and is on display in the KMA office. Thank God the high ideals to which those 25 women aspired and which the Alliance still sustains did not go in the case with the gavel.

Capitalizing on the energy and expertise with which our past presidents and members have built a solid foundation, we continue to celebrate the

successes that manifest the amazing accomplishments of Alliance members, four examples being: in Perry County, the comprehensive school program, Growing Healthy; in Fayette and Jefferson Counties, the S.M.A.R.T. program which teaches about the

risks of smoking; in Boyd County, record-breaking contributions year after year to the American Medical Association Education and Research Foundation; and on the state and county levels, the granting of health-career scholarships.

Members in every county contribute special talents that enhance the work of this organization, but it would take too many pages to cover the achievements of just the past 2 years under the capable leadership of Joyce Clark and Marla Vieillard.

In the bigger picture, new programs will evolve, as counties see fit. The most valuable asset of any organization weighs approximately three pounds and is invisible to most people — the human brain. We will continue to tap its creative imagination, encouraging not only members with traditional concepts but also newer members who, with fresh insights, make unique contributions.

While initiating new programs, the real challenge is to discontinue policies or projects proven ineffective relevant to the cost of time and en-

“While initiating new programs, the real challenge is to discontinue policies or projects proven ineffective relevant to the cost of time and energy. New ideas need empty space in which to develop.”

“The most valuable asset of any organization weighs approximately three pounds and is invisible to most people — the human brain.”

ergy. New ideas need empty space in which to develop. Models from the past may not work in the future. We must trust and affirm innovation.

As we applaud those 25 women who started the Alliance on its bold journey and the litany of resourceful leaders who have followed them over the last seven decades, we reiterate their commitments: to nurture fellowship among physicians' families, to provide a healthier lifestyle for those within the scope of our influence, to inform ourselves and others of the im-

pact of legislation, and, above all, to foster a positive image of medicine.

We are grateful to Danny M. Clark, MD, KMA President, Mr Robert G. Cox, KMA Executive Vice-President, and all the other Kentucky Medical Association leaders, members and staff for their generous support and their willingness to help the Alliance fulfill its destiny.

Ruth Ryan
KMAA President

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PEOPLE

Scott B. Scutchfield, MD, a Danville orthopaedic surgeon, has been appointed to the board of directors of the American Academy of Orthopaedic Surgeons.

Dr Scutchfield is assistant clinical professor, Department of Orthopaedic Surgery, University of Kentucky College of Medicine, and a member of the executive committee of the Kentucky Orthopaedic Society, having served as its president from 1989-91. He also is a past president of the Boyle County Medical Society, and currently serves KMA as Vice Chair of the Board of Trustees and as 12th District Trustee.

Active in the Academy, Dr Scutchfield has been Kentucky's representative on the Academy's Board of Councilors since 1993, and currently is its secretary. He also is the Board of Councilors representative to the AMA and the Clinical Policy Committee on the Hip.

Dr Scutchfield has been the Kentucky Orthopaedic Political Action Committee Chairman since 1994 and is a regional representative for the Orthopaedic Research and Education Foundation.

Mohammad Amin, MD, a urological surgeon, recently celebrated his 25th anniversary in the University of Louisville School of Medicine Department of Surgery.

Peter E. Tanguay, MD, U of L Department of Psychiatry, received the Meritas-Tabaret Award, the highest alumni association award from the University of Ottawa, at a recent celebration of the Faculty of Medicine's 50th anniversary. Dr Tanguay was recognized as one of the world's top researchers in infantile autism and Asperger's disorder.

Steven J. Reiss, MD, has been elected President of the Caritas

Medical Center medical staff for 1996. Other new officers include **L. Pete Moore, MD**, President-Elect; and **Warren F. Kemper, MD**, Secretary/Treasurer.

Richard M. Garrison, MD, U of L Department of Surgery, was selected as the recipient of the 1995 Robert D. and Alma W. Moreton Original Research Award. The award was presented at The Southern Medical Association's 89th Annual Scientific Assembly, during the President's Doctors' Day Awards luncheon.

UPDATES

HIV/AIDS Education for Physicians

The KMA would like to remind physicians to obtain their 2 hours mandatory HIV/AIDS education before December 31, 1996.

The Kentucky Department for Health Services reports that many physicians have not met the education requirement which will apply when the Kentucky license renewal period begins in 1997.

To obtain a list of Kentucky Cabinet for Human Resources home study courses, call the Kentucky AIDS Education Program Department at 502/564-6539.

Medicare Physician Coding Clampdown

Medicare is clamping down on coding errors in a widespread initiative concerning physician payments. In an effort that started on January 1, 1996, Medicare carriers now run all claims through new computerized screens designed to identify physicians who bill for incorrect combinations of services, such as billing for both an x-ray of the

upper gastrointestinal tract and one of the abdomen (the first includes the second). The screens are programmed to spot more than 87,000 incorrect combinations of so-called comprehensive and component codes.

A GAO report released in May concluded that using similar commercial products for screening claims would have saved Medicare \$603 million in 1993 and \$640 million in 1994.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyd

Michael E. Daun, MD — OPH
2301 Lexington Ave Ste 305, Ashland 41101
1987, U of Utah
Timothy K. Dixon, MD — U
2301 Lexington Ave Ste 130, Ashland 41101
1984, U of Louisville

Grayson

Michael E. Fletcher, MD — AN
908 Wallace Ave Ste 202, Leitchfield 42754
1991, U of Louisville

Henderson

Michelle B. O'Neill, MD — EM
827 Bent Tree Ln, Henderson 42420
1982, U of S California

Hopkins

Donald W. Blair, MD — N
200 Clinic Dr, Madisonville 42431
1977, New York University
Mirek T. Sochanski, MD — C
200 Clinic Dr, Madisonville 42431
1982, Warsaw, Poland

Jefferson**Mirza Ahmed, MD** — C2100 Stony Brook Dr Apt 1422,
Louisville 40220
1986, Dow, Pakistan**Paul C. Brooks, DMD**

233 E Gray St Ste 719, Louisville 40202

Joseph H. Cieslak, DDS225 Abraham Flexner Way Ste 302,
Louisville 40202**Edward T. Haines, MD** — S2504 Dundee Rd, Louisville 40205
1966, U of Chicago**Vinay Puri, MD** — N250 E Liberty St Ste 202, Louisville
40202

1989, Kasturba, India

Mukunda B. Ray, MD — PTHUL Dept of Pathology, Louisville 40292
1967, Dacca, Bangladesh**Rona Jean Roberts, MD** — PD1382 S Second St, Louisville 40208
1992, U of Louisville**Michael J. Sundine, MD** — PS601 S Floyd St Ste 700, Louisville
402021987, St. Louis College of Physicians
and Surgeons**Wayne G. Villanueva, MD** — NS225 Abraham Flexner Way Ste 505,
Louisville 40202
1989, Columbia**Pike****Leslie V. Hill, MD** — OBG261-277 Town Mt Rd, Pikeville 41501-
1628
1983, Dalhouse U, Canada**Scott****William G. Platz, MD** — P4071 Tates Creek Rd 202, Lexington
40517
1988, U of Iowa**Taylor****David A. Montgomery, MD** — IM95 Kingswood Dr, Campbellsville
42718
1992, U of Louisville**In-Training****Jefferson****Mini J. Aggarwal, MD** — FP**Gregory P. McComis, MD** — ORS**DEATHS****Yosh Maruyama, MD****Gross Pointe, MI****1930-1995**

Yosh Maruyama, MD, a retired radiologist living in Michigan, died January 11, 1995. A 1955 graduate of the University of California School of Medicine, Dr Maruyama was a life member of KMA. *The Journal just recently received notification of Dr Maruyama's death and regrets the delay in this report.*

William V. Schulte, MD**Lexington****1924-1995**

William V. Schulte, MD, a retired OB/GYN, died October 7, 1995. Dr Schulte was a 1946 graduate of the University of Louisville School of Medicine and a life member of KMA.

Robert R. Starr, MD**Glasgow****1917-1996**

Robert R. Starr, MD, a retired family practitioner, died January 25, 1996. A 1943 graduate of the University of Louisville School of Medicine, Dr Starr was a life member of KMA.

James A. Freeman, Jr, MD**Dawson Springs****1916-1996**

James A. Freeman, Jr, MD, a retired family practitioner, died January 31, 1996. Dr Freeman graduated in 1940 from the University of Maryland School of Medicine and was a life member of KMA.

Benjamin Prada, MD**Louisville****1918-1996**

Benjamin Prada, MD, a retired general surgeon, died February 15, 1996. A 1948 graduate of National University, Columbia, Dr Prada was a life member of KMA.

Guy C. Cunningham, MD**Lexington****1921-1996**

Guy C. Cunningham, MD, a retired pediatrician, died March 9, 1996. Dr Cunningham graduated in 1946 from the University of Louisville School of Medicine, and served a four-year term on the state Board of Health, being appointed in 1971 by then-Governor Louie B. Nunn. He was a life member of KMA.

Clovis A. Crabtree, MD**Louisville****1929-1996**

Clovis A. Crabtree, MD, a psychiatrist, died March 16, 1996. A 1954 graduate of the University of Tennessee College of Medicine, Dr Crabtree was an active member of KMA.

Carroll H. Robie, MD**Louisville****1923-1996**

Carroll H. Robie, MD, a retired internist, died March 17, 1996. A 1949 graduate of Ohio State University College of Medicine, Dr Robie was a former governor of the Kentucky unit of the American College of Physicians, a former KMA vice president, and a life member of KMA.

RATES AND DATA

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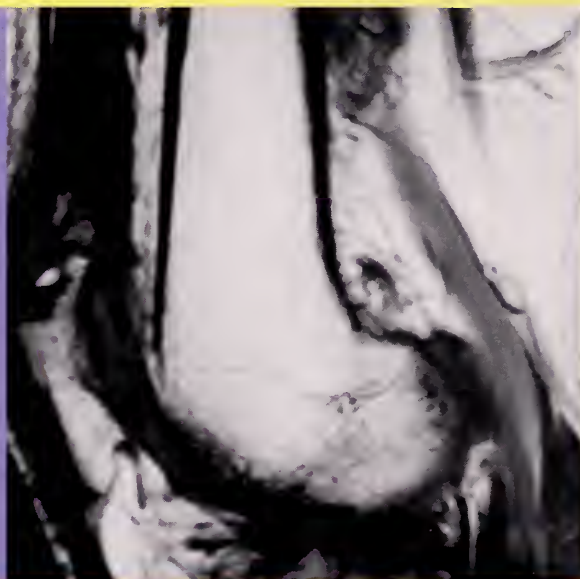


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JUNE 1996
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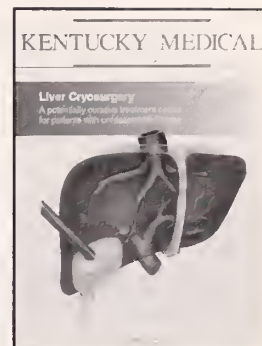
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VOLUME 94, NUMBER 6

JUNE 1996

| | | |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------|
| COVER STORY | Liver Cryosurgery (Grand Rounds) <i>Kelly M. McMasters, MD, PhD; Michael J. Edwards, MD</i> | 222 |
| SCIENTIFIC | ECT-Induced Seizure Durations <i>Scott Haas, MD; Kenneth Nash, MD; Steven B. Lippmann, MD</i> | 233 |
| SPECIAL ARTICLE | The Prevalence of Genetic Disorders, Birth Defects and Syndromes in Central and Eastern Kentucky <i>Ronald G. Cadle, MS; Tasha Dawson; Bryan D. Hall, MD</i> | 237 |
| EDITORIAL | Not Quite Like Buying a Refrigerator <i>Milton F. Miller, MD</i> | 243 |
| ASSOCIATION | Monitoring Medicine Spring KMA Board Meeting AMA's New "EVP" Application for Annual Meeting Scientific Exhibits Awards Nomination Form News | 219 247 251 244 255 248 |
| DEPARTMENTS | President's Page Advertisers' Guide Alliance Page Classifieds Information for Authors | 217 254 245 253 241 |



COVER: This month's cover introduces on article on liver cryosurgery, a relatively new form of treatment for unresectable liver cancer that involves in situ obliteration of liver tumors by freezing them with liquid nitrogen. See page 222.

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KMA

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Danny M. Clark, MD

Indifference Engenders Shackles

On May 28 Kentuckians went to the polls. In a Primary Election which many political pundits characterized as the most significant election in years, the majority of eligible voters stayed home, yawned, and continued griping — and sniping at their elected officials. In 1994 KEMPAC, KMA's political arm, and the KMA Alliance sponsored a voter registration drive. Their goal was to assure that every physician and spouse was registered to vote. Frankly, I found this project — while grudgingly necessary — shockingly incongruous. The embarrassing fact that a comparatively high number of physicians and spouses are either nonregistered or fail to vote casts a dark cloud over the profession.

In 1996 we will elect a President — a US Senator — 6 of 6 Congressional seats — 19 of 38 State Senators — and 100 of 100 House of Representative seats. Every single one of these candidates will have a significant impact upon your professional, economic, social, and personal lives. From an economic standpoint, Medicare, Medicaid,

Workers' Compensation, and other government compensation now represents approximately 50% of physicians' income. Consequently, elected officials have a deep and abiding interest in our incomes. These are also the people who will by and large lead us into the new millennium.

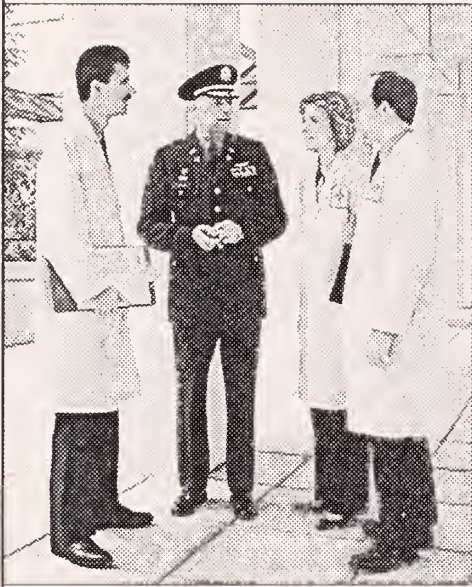
But getting even more personal — here and now — these folks will chart the future course for our profession. Far too often physicians overly concern themselves with Washington politics — ignoring the folks who can really make your life miserable — that "Frankfort gang of 138." That relatively unknown individual in your local community who suddenly becomes a State Senator or Representative will among other more important responsibilities — determine and then cast votes on all matters relating to the Medical Practice Act — decide whether to reimpose a provider tax — reenact health system reform — determine Medicaid and Workers' Compensation fees — or enhance nonphysician practitioners practice acts.

No other nation has been more blessed with such a marvelous political system than has these United States of America. The crafters of the US Constitution carefully erected checks and balances between the legislative, the administrative, and the court system. Then they provided for the direct election of our officials — and made sure they faced the electorate periodically. What they never envisioned was the gross indifference of the American Citizen in the 1990s.

Casting a vote — contributing to a political candidate — working to elect competent elected officials IS AMERICAN PIE! Physicians and their families have been enormously rewarded by our system of government and justice. We have a moral responsibility to our profession — to our family — to our Government — and to our Maker to exercise Democracy. In the words of Thomas Buxton, "Laziness grows on people; it begins in cobwebs and ends in iron chains."

Danny M. Clark, MD
KMA President

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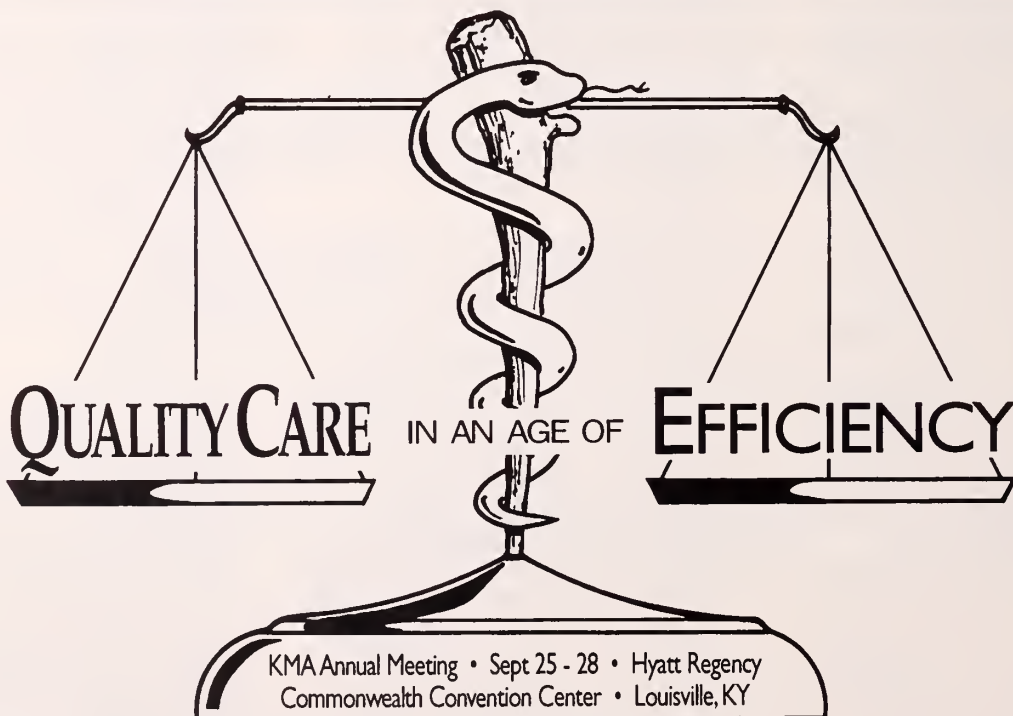
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MONITORING MEDICINE

NEWS FOR KENTUCKY PHYSICIANS

Governor Paul Patton is considering calling the Kentucky General Assembly into Special Session this summer to address Workers' Compensation. On May 16 William E. Doll, Jr, KMA Legislative Counsel, presented the following testimony on behalf of the Association.

KMA represents about 80% of the active practicing physicians in Kentucky. A substantial number of these physicians provide care to patients suffering from work-related injuries or occupational diseases. But it is not the rendition of care — its quality, frequency, or the type of care — on which I intend to focus. Rather, I want to talk about health care costs, and the things that have been done to address them within Kentucky's Workers' compensation program.

A one line summary at my presentation would be that as a result of legislative, regulatory, and market changes effected since 1987, Kentucky physicians have already "paid their price" when it comes to Workers' compensation; and, therefore, it is time to move on to more comprehensive reform, rather than continue to tinker with an element that is more a symptom of a diseased system than a cause of its problems.

A brief chronology of change in this area, coupled with a review of facts and statistics provided by objective sources, will help you understand why I can make such a claim.

Prior to 1987, there was no governmentally imposed fee schedule in Kentucky. As a result of legislation enacted during the November 1987 special session,

such a schedule was established. It required, among other things, that "all [medical] fees, charges and reimbursements . . . be fair, current and reasonable . . . the same as if such treatment is paid for by the injured person himself."

In 1994, HB 928 further modified this provision. The new legislation retained the requirement that fees be "fair, current and reasonable" but changed the standard to one "where treatment is paid for by general health insurers," rather than being paid by ". . . the injured person himself."

HB 928 also required the following: ". . . the commissioner shall execute a contract with an appropriately qualified consultant pursuant to which each of the following elements within the workers' compensation system are evaluated: the methods of health care delivery; quality assurance and utilization mechanisms; type, frequency, and intensity of services; risk management programs; and a schedule of fees contained in administration regulation. The consultant shall present recommendations based on its review to the commissioner not later than 60 days following execution of the contract. The commissioner shall consider these recommendations and, not later than 30 days after their

receipt, promulgate a regulation which shall be effective on an emergency basis, to effect a twenty-five percent (25%) reduction in the total medical costs within the program."

To one extent or another, all those requirements have been met. The '87 fee schedule was established, using many fees and modifiers derived from an Oklahoma fee schedule that was at least 2 years old. On the heels of HB 928, still another fee schedule was crafted. I won't attempt to tell you what it did . . . but I will let analyses and statements of others speak for themselves in providing that assessment.

On page 64 of the report covering your April 18, 1996, public hearing, statements derived from Commissioner Turner's presentation indicate:

- Independent consultants and Workers' Compensation Research Institute ("WCRI") confirm that the new fee schedules have reduced medical reimbursement by 25%.
- Recently released reports reflect that for 1995, Kentucky is the 6th most conservative jurisdiction in the country for medical reimbursements.

One of the "independent consultants" referred to by Commissioner Turner is Medicode, a corporation operating out of

Salt Lake City, Utah. Excerpts from a March 11, 1996, Medicode report to Commissioner Turner further illustrate how Kentucky's workers' comp medical costs rank on a national scale.

- This comparison illustrates that the current Kentucky Hospital Fee Schedule is significantly lower than group health reimbursements. This is consistent with the Medical Fee Schedule for Physicians which most closely compares to Medicode's 25th percentile of Usual, Customary, and Reasonable ("UCR"), which is approximately 75% of what is typically allowed in the group health portion of the industry.
- In a comparison of the 1989 and 1994 Medical Fee Schedules for Physicians, Medicode found that the 1994 schedule reflects fees that, overall, are 25% lower than those included in the 1989 schedule. This comparison was based on 100 of the most commonly performed procedures in workers' compensation. With physician costs accounting for 39% of the overall medical costs, this 25% reduction results in a 10% savings in the total workers' compensation medical expenses.

Medicode also looked at the potential impact of utilization review and managed care on medical costs. It observed that:

- The current Hospital Fee Schedule and Medical Fee Schedule for Physicians alone have resulted in a potential 25% savings in the overall medical costs in comparison to the 1989 schedule. With the effect of utilization review ("UR") and managed care, which have also undergone significant changes since the 1989 schedule, it is Medicode's opinion that the savings most likely will exceed the goal of 25%.

Recall Commissioner Turner's response to the Council's question about utilization of the managed care provisions of HB 928. As set out on page 66 in the report of your first hearing, Commissioner Turner indicated that ". . . there are 18 approved managed care systems in the state for industrial health care. Roughly 16% of the work force is now covered by a managed care system. Self-insureds have moved into the managed care arena faster than the insurance carriers. KEMI is moving toward managed care."

A "Notice of Intent to Amend" the current utilization review and bill audit regulation was circulated on April 11, 1996. As utilization review and quality assurance programs become more effective, those efficiencies should

be translated into additional reductions in the medical costs of the program.

This evidence should greatly diminish if not end the clamor about workers' comp medical costs. I accept, however, that what should occur may not occur. Medical costs provide a convenient target; it's easy to get people angry at allegedly greedy doctors and overreaching hospitals. And once people begin bashing the health care folks, they're distracted from the need for systemic or comprehensive change. That kind of distraction may be the top priority for those who want to maintain the status quo.

Medical costs have been a problem; the question is "Why?" When you have workers' comp claims increasing three- and fourfold, it should come as no surprise that medical costs increase as well, particularly when you consider the inflationary spirals this country has experienced. Claims went from 4,000 in 1989 to 12,000 in 1993 (see p 63, report of April 18, 1996, Council meeting). Someone has to provide care to these claimants, and evaluate their injuries and illnesses. Someone has to fill out the forms; create the treatment plans; explain the prognosis to the claimant, the employer, the claims adjuster or the rehabilitation coordinator. Someone has to testify about the nature and quality of the injury or

illness either through a deposition, direct testimony, or some sort of report. That is the system — for good or bad. In the process, someone gets paid for these services. And there's your bogeyman; or, maybe, your scapegoat. Physicians didn't create this program; as care givers they are necessarily a part of it, but they are certainly not responsible for the way it works or the way it's structured.

Don't let your aim wander from the real target. Quoting from page 6 of the Council's initial report,

The principal culprit precipitating astronomic growth in Kentucky's workers' compensation costs has been utilization of the system itself. Medical inflation and the extent and duration of injury . . . pale as cost drivers in comparison to escalating utilization of the system.

And it's the system which allows that to occur; it's the thing you must bring in check. Otherwise, Paul Jones' remarks from the last meeting will be forever accurate. As he noted, and I paraphrase, "You don't have to commit fraud or abuse in this system . . . it's so wide open you can get away with anything without running afoul of the law."

One additional cautionary remark — there is a "margin of diminishing returns" in all of this. We've already begun to hear an outcry from patients and

consumers about the alleged evils of managed care in the general health insurance market. Costs have been ratcheted down by either narrowing the scope of insurance coverage, refusing to pay for certain services, or extracting substantial fee discounts from medical providers.

Those cost-saving mechanisms may be legitimate as long as there is "excess" or "fat" in the system. If that "fat" is eliminated, yet cuts continue, someone will suffer in order for those operating the managed care system to expand or maintain their profit margin. Access to and quality of care will diminish.

So, be wary. As managed care in workers' comp continues to expand, you may see further reductions of health care costs within the system. Be sure these are true savings and not just a shift of dollars from the pockets of providers and premium payers to those of insurance companies and others running managed care systems. If fees are reduced to the point where it is no longer economically feasible to provide care to those truly injured or ill as a result of their employment, no one's better interest is served. The same is true if the managed care rules are so stringent or convoluted that access to care is inappropriately limited. To that extent, you must be careful not to make the system worse as you seek to cure its ills.

Liver Cryosurgery

A potentially curative treatment option for patients with unresectable disease

Kelly M. McManus, MD, PhD, William J. Edwards, MD



Liver cryosurgery is a relatively new form of treatment for unresectable liver cancer that involves in situ ablation of liver tumors by freezing them with liquid nitrogen. Cryosurgery has been used mainly to treat liver metastases from colorectal cancer, but other types of metastases and primary liver cancers have been treated as well. Results of liver cryosurgery over the past decade have demonstrated that it is a safe and effective treatment for malignant liver tumors. Because only a small percentage of primary and metastatic liver tumors are resectable, cryosurgery offers a potentially curative treatment option for patients with unresectable disease.

Liver Metastases from Colorectal Cancer

Colorectal carcinoma is the second leading cause of cancer death in the United States, with approximately 150,000 new cases and 55,000 deaths occurring annually.¹ Fifty percent of patients with colorectal cancer (75,000/year) will develop metastatic disease. Of these patients, approximately 60% (45,000/year) will have liver metastases, but only 20% (15,000/year) will have metastatic disease confined to the liver. About 25% of patients with liver-only metastases (3750/year) will be candidates for surgical resection.² Cryosurgery is a relatively new treatment modality that is targeted toward patients with unresectable metastases confined to the liver (11,250/year).

Treatment Options. Patients with colorectal metastases may be considered in three categories: resectable liver metastases, unresectable liver metastases, and those with extrahepatic disease. Table 1 lists the available treatment options according to each category. Treatment goals should be clearly defined as curative or palliative. Patients with resectable liver metastases must also be medically fit to undergo major liver resection. Hepatic metastases are considered unresectable because of size, number, bilobar distribution, or central location. The unresectable category also includes patients who are at risk for major hepatic resection because of comorbid disease or insufficient hepatic reserve. Patients with extrahepatic disease do not benefit from surgical resection or other locoregional treatments and require systemic chemotherapy.

Surgical resection, when possible, remains the treatment of choice for patients with liver me-

tastases from colorectal cancer. Five-year survival rates range from 16% to 40%, with a median survival of 22 to 30 months (Table 2).³⁻²⁰ Conventional treatment for unresectable colorectal metastases confined to the liver includes systemic chemotherapy and hepatic artery infusion (HAI) chemotherapy. These treatments are strictly palliative; long-term survival is rare. The results of randomized, prospective trials comparing systemic chemotherapy with HAI chemotherapy are presented in Table 3.²¹⁻²⁵ Standard chemotherapy for metastatic colorectal cancer consists of 5-fluorouracil (5-FU) in combination with leucovorin, and results in median survival rates of 10.5 to 14.4 months.²⁶⁻³¹ Radiation therapy,³²⁻³⁶ chemoembolization,³⁷ ethanol injection,^{38,39} and other forms of treatment⁴⁰ have not been proved to be effective for liver metastases from colorectal cancer.

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Table 1. Treatment Options for Colorectal Cancer Metastatic to the Liver

| Category | Potentially Curative | Palliative |
|------------------------|----------------------|--------------------------------------------------|
| • Resectable | Resection | NA |
| • Unresectable | Cryosurgery | Hepatic Artery Infusion Systemic Chemotherapy |
| • Extrahepatic Disease | Rare | Systemic Chemotherapy |

NA, not applicable.

Table 2. Survival After Hepatic Resection for Colorectal Metastases

| Study, year | No. of Patients | 5-Year Survival Rates (%) | Operative Mortality Rates (%) |
|--------------------------------|-----------------|---------------------------|-------------------------------|
| Hughes, 1989 ³ | 800 | 32 | NA |
| Faster, 1981 ⁴ | 231 | 23 | 6 |
| Scheele, 1990 ⁵ | 219 | 39 | 5.5 |
| Adson, 1984 ⁶ | 141 | 25 | 4 |
| van Ooijen, 1992 ⁷ | 118 | 21 | 7.6 |
| Savage, 1992 ⁸ | 104 | 18 | NA |
| Iwatsuki, 1989 ⁹ | 86 | 38 | 0 |
| Nardlinger, 1987 ¹⁰ | 80 | 25 | 5 |
| Ekberg, 1986 ¹¹ | 72 | 16 | 5.6 |
| Fartner, 1984 ¹² | 65 | 40 | 7 |
| Butler, 1986 ¹³ | 62 | 34 | 10 |
| Sesta, 1987 ¹⁴ | 61 | 28 | 7 |
| Wilsan, 1976 ¹⁵ | 54 | 28 | 1.7 |
| Lind, 1992 ¹⁶ | 52 | 28 | 9 |
| | | Median Survival | |
| Steele, 1991 ¹⁷ | 87 | 29 mo | 2.7 |
| Gennari, 1986 ¹⁸ | 48 | 30 mo | 2.1 |
| Petrelli, 1985 ¹⁹ | 36 | 22 mo | 14 |
| Bradpiece, 1987 ²⁰ | 24 | 30 mo | 8 |

NA, not available.

Liver Cryosurgery

Table 3. Randomized trials comparing hepatic artery infusion chemotherapy (fluorodeoxyuridine) to intravenous systemic chemotherapy (5-fluorouracil or fluorodeoxyuridine).

| Study, year | No. of Patients | Median Survival (months) | |
|-----------------------------|-----------------|--------------------------|-------------------------|
| | | Intravenous | Hepatic Artery Infusion |
| Chang, 1987 ²¹ | 64 | 12 | 17 |
| Martin, 1990 ²² | 69 | 10.5 | 12.6 |
| Kemeny, 1987 ²³ | 99 | 12 | 17 |
| Hohn, 1989 ²⁴ | 115 | 16.1 | 16.8 |
| Rougier, 1992 ²⁵ | 163 | 11 | 15* |

* Significantly different versus intravenous systemic chemotherapy ($P < 0.02$).

Cryosurgery is a potentially curative treatment modality for patients with unresectable colorectal metastases confined to the liver, and it is also a possible treatment for carefully selected patients with liver metastases from other primary tumors as well. Cryosurgery is an operative procedure that involves destruction of liver tumors by the process of rapid freezing with liquid nitrogen, followed by slow thawing. Furthermore, cryoablation of small blood vessels contributes to tissue hypoxia and cell death. The likelihood of complete necrosis is increased by two or more freeze-thaw cycles. The tumor(s) are then left *in situ* and the necrotic tissue is reabsorbed over time. Cryoablation causes a predictable and reproducible pattern of tissue destruction, preserves more hepatic parenchyma than resection, and can be used for bilobar metastases and centrally located lesions.⁴¹⁻⁴⁷

Preoperative Evaluation. Preoperative assessment of all patients with liver metastases includes a thorough history and physical examination to exclude extrahepatic disease and to assess operative risk. Colonoscopy should be performed to rule out anastomotic recurrence or metachronous colon cancer. A computed tomography (CT) scan of the abdomen and pelvis should be performed to examine not only the extent of liver involvement but to look for evidence of extrahepatic metastases. A chest x-ray should also be obtained to evaluate lung metastases. Routine laboratory studies should include a carcinoembryonic antigen (CEA) level test, a complete blood count, liver function tests, and prothrombin time and partial thromboplastin time.

Patients with documented extrahepatic metastases are referred for systemic chemotherapy. Those with metastases that are potentially amena-

ble to resection, cryosurgery, or hepatic artery chemotherapy should undergo CT angioportography. This technique is more sensitive than the standard CT scan to detect liver metastases. It also includes superior mesenteric artery and celiac axis angiography to define the arterial anatomy of the liver.

Results of this evaluation aid in the selection of appropriate treatment. Some patients have a single metastasis, which because of size and location, is clearly amenable to resection. Others have liver metastases that are clearly unresectable. For many patients with multiple metastases or centrally located lesions, it is often difficult to decide preoperatively whether they would be best served by resection, cryosurgery, a combination of resection and cryosurgery, or intra-arterial chemotherapy. For this reason, patients are counselled regarding the risks and benefits of each treatment option. Informed consent is often obtained for all three procedures, followed by intraoperative determination of appropriate therapy. The chance of finding extrahepatic disease at operation is approximately 30%,² and this is explained to the patient preoperatively.

Operative Approach

Abdominal Exploration. At operation, thorough abdominal exploration is performed to search for extrahepatic metastases. Biopsies of enlarged portal, mesenteric, or para-aortic lymph nodes or peritoneal implants are submitted for frozen section analysis. The finding of extrahepatic disease necessitates closure of the patient's abdomen without further treatment, and he or she is referred for systemic chemotherapy.

Intraoperative Ultrasonography. If there is no evidence of extrahepatic disease, intraoperative ultrasonography (IOUS) is performed. It is more sensitive than a CT scan or surgical inspection/palpation, and it is the gold standard for detection of small hepatic lesions. IOUS also provides invaluable information on the relationship of the tumor(s) to major hepatic blood vessels. The IOUS findings ultimately determine the appropriate course of action intraoperatively.²

Selection of Operative Treatment. Resection is performed, if possible, given the size and location of the tumor(s) and the patient's overall medical condition and hepatic function. Occasionally, cryoablation and resection are performed in the same patient. For example, left he-

patic lobectomy can be performed with cryoablation of a lesion deep within the right lobe, or vice-versa. Cryosurgery-alone is performed if resection is not possible and the metastases can be adequately treated with this method. If IOUS findings indicate that neither resection nor cryosurgery is feasible, a hepatic artery pump for intra-arterial chemotherapy postoperatively is considered.

Cryosurgery. Cryosurgery is performed by placement of a needle through the center of the tumor under IOUS guidance. Using the Seldinger technique, a probe (Fig 1) is then positioned through the center of the tumor. IOUS is essential for proper placement of the probe and for monitoring of the extent of freezing to ensure that each lesion is totally encompassed in the ice ball with a margin of 1 cm of normal tissue. Adjacent organs are protected from freezing by packing with laparotomy sponges. The probe is then cooled using the cryosurgery machine (Fig 2). After freezing to -180°C to -190°C for 15 minutes, slow thawing is allowed to take place for 10 minutes (Fig 3). The cycle is then repeated. After removing the probe, the tract is packed with absorbable hemostatic material, and the probe site is treated with an argon beam coagulator to control hemorrhage. The necrotic tumor is left *in situ* to be reabsorbed (Figs 4A and B).

Results of Cryosurgery

Based on initial results, survival rates following cryosurgery are similar to those of liver resection. Ravikumar et al⁴⁸ reported the results of cryosurgery for 24 patients with colorectal metastases. At a median follow-up of 24 months, 7 patients (29%) were alive and disease-free, 8 (33%) were alive with recurrent disease, and 9 (38%) patients had died. Analysis of patterns of failure revealed that 1 patient (6%) developed extrahepatic disease only, 6 patients (35%) had recurrence of disease in the liver only, and 10 patients (59%) developed recurrent disease in both hepatic and extrahepatic sites. In another series, 21 patients (17 colorectal carcinoma metastases, 4 hepatocellular carcinoma) were treated with cryosurgery.⁴⁹ At a median follow-up of 16 months, 5 patients (24%) had a complete response, as defined by complete resolution of tumor on CT scan, and remained disease-free; 5 patients (24%) developed recurrent disease within the liver (2 adjacent to the cryoablated area); while 11 patients (52%) devel-



Fig 1 — A liquid nitrogen-cooled probe used for liver cryosurgery. Top inset, the freezing zone of the conical-shaped probe is depicted. Bottom inset, the shape of the probe is illustrated (Courtesy of Cryomedical Sciences, Inc, Rockville, MD).



Fig 2 — The AccuProbe® System used for cryosurgery. (Courtesy of Cryomedical Sciences, Inc).

Liver Cryosurgery



Fig 3 — An intraoperative photograph of cryoablation of a colorectal metastasis in the right lobe of the liver. Note the ice ball on the undersurface of the liver. (Courtesy of Dr Mark S. Roh, MD Anderson Cancer Center, Houston, TX).

oped systemic metastases.

The largest series reported is from Allegheny General Hospital (Pittsburgh, PA), where 157 patients were treated with cryosurgery,⁵⁰ including 130 patients with colorectal metastases, 10 with carcinoid tumors, 7 with metastatic sarcoma, and 10 with various other primary tumors. Patients were considered for cryosurgery if they had <10 hepatic lesions and <50% of the liver volume replaced by tumor. Using this aggressive approach, the overall median survival was 22 months. Patients followed for ≥ 2 years had a median survival of 26 months.

Based on these results, cryosurgery appears to be an effective treatment option for patients with unresectable liver metastases from colorectal cancer. Because cryosurgery is reserved for patients with unresectable tumors, the overall prognosis of these patients is worse than for pa-

tients with resectable disease. Available studies of cryosurgery have included patients with a large volume and number of liver metastases. There is no clear consensus in the literature regarding the number and size of tumors that should be treated. However, it is becoming apparent that patients with widespread metastases do not often benefit from cryosurgery. Currently at the MD Anderson Cancer Center (Houston, TX), the presence of more than five metastases, or size of the largest metastasis >5 cm, are considered relative contraindications to cryosurgery. Furthermore, tumors adjacent to large blood vessels appear more difficult to treat effectively because rapid blood flow creates a "heat sink" effect. There is also concern in treating lesions that are near the confluence of the hepatic ducts because of potential biliary tract complications. More stringent selection criteria may improve the overall results.

Cryosurgery with Adjuvant HAI Chemotherapy

Although the rate of local recurrence at the cryoablated site is approximately 10%,⁴⁹ many patients are at high risk for developing metastases elsewhere in the liver. Recently, the possibility of combining cryosurgery with postoperative HAI chemotherapy has been investigated in an attempt to reduce recurrence within the liver. In a retrospective cohort analysis, Preketes and colleagues⁵¹ reported on a series of 38 patients who underwent cryosurgery for colorectal carcinoma metastatic to the liver, all of whom received a hepatic artery pump for postoperative chemotherapy. Eleven patients received either no HAI chemotherapy (4 patients) at the decision of the treating physician, or received <3 months of HAI chemotherapy (7 patients) because of pump/catheter malfunction or toxicity. Twenty-seven patients received intra-arterial therapy with 5-fluorouracil (5-FU), with leucovorin delivered orally or intra-arterially. The groups were well-matched in terms of number and size of metastases and stage of primary disease. The group that received <3 months of HAI chemotherapy after cryosurgery had an actuarial median survival of 245 days versus 570 days for the group that received >3 months of HAI chemotherapy.

Ravikumar et al⁵² recently reported the initial results of a phase I/II trial of cryosurgery combined with HAI chemotherapy. Twelve patients with <40% estimated liver freeze volume and a median of three metastases (range, 3 to 10) underwent cryoablation, followed by 1 year of HAI chemotherapy with a regimen of alternating 5-FU and fluorodeoxyuridine (FdUrd). The HAI regimen was well tolerated by all but 1 patient who had elevated liver function test results concomitant with rapid disease progression within the liver. At a median follow-up of 24 months, 6 of 12 patients (50%) were alive and disease-free. The site of initial recurrence was the lung in four patients and the liver in two others.

These results suggest that adjuvant HAI chemotherapy may improve survival following cryoablation of liver metastases from colorectal cancer. Multi-institutional phase II and III trials are warranted to further investigate the potential benefit of combination cryosurgery and HAI chemotherapy.

Complications of Cryosurgery

The results of cryosurgery for primary or meta-

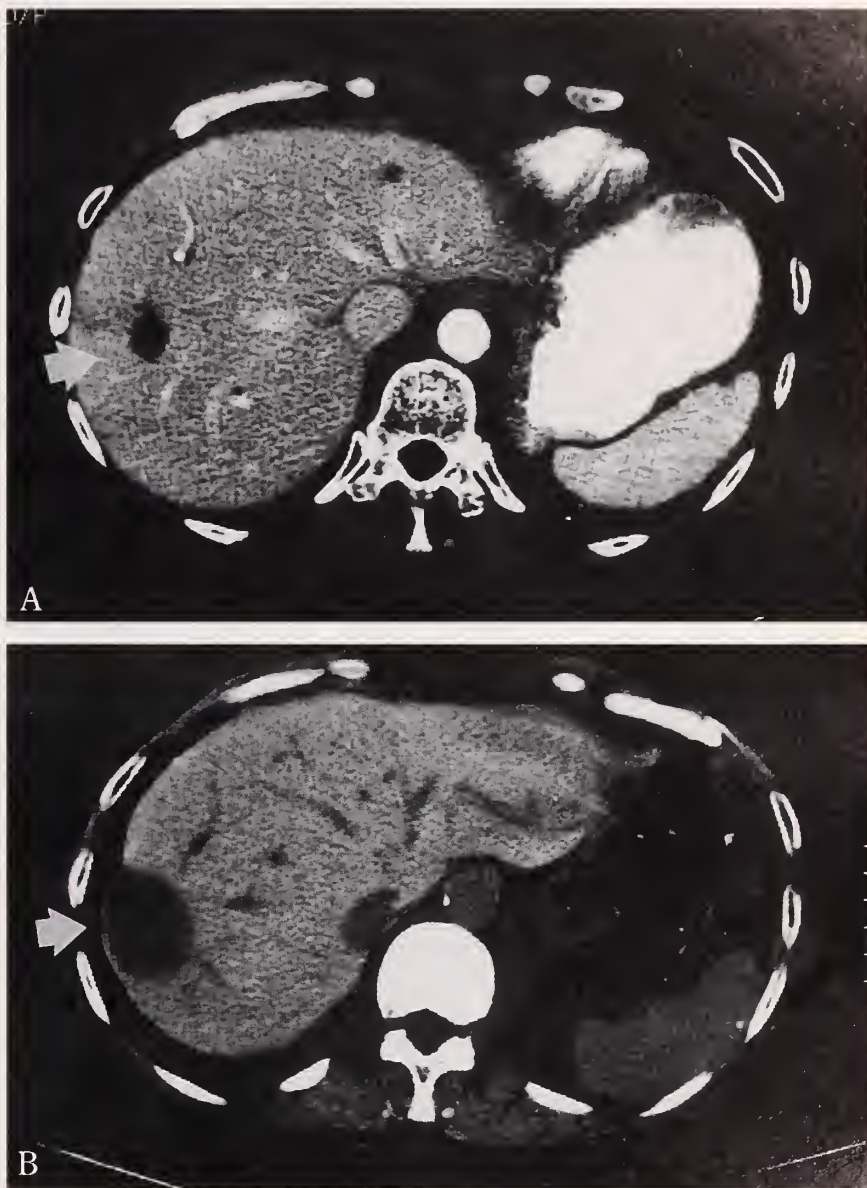


Fig 4 — A, preoperative CT angiogram of the patient shown in Fig 3. A metastasis is present in the right lobe of the liver (arrow). The small lesion shown in the left lobe of the liver was a cyst. B, CT scan 6 months postoperatively shows the cryoablated site (arrow).

static liver tumors have been reported in over 400 patients, with only 6 operative deaths.^{44,53} Complications were infrequent and included major hemorrhage from cracking of the frozen liver, liver abscess, subphrenic abscess, biliary fistula, and wound dehiscence. Most patients developed a transient right pleural effusion. Many patients developed transient postoperative fever, leukocytosis, and had elevated liver function test results

without evidence of infection. Renal insufficiency has also been reported in a few patients, although dialysis has not been required. Because myoglobinuria is detectable in all patients following cryosurgery, administration of mannitol, renal dose dopamine, and alkalization of the urine by administration of sodium bicarbonate are performed intraoperatively to protect renal function.

Treatment of Primary Liver Cancer

Cryosurgery has also been used for patients with unresectable primary liver cancer, most with hepatocellular carcinoma. In a series from China, 107 patients (104 with hepatocellular carcinoma, 1 with cholangiocarcinoma, 2 with mixed type) were treated with cryosurgery, alone or in combination with resection or hepatic artery ligation and/or perfusion.⁵³ Eighty-six percent of patients had cirrhosis and 33% had tumors <5 cm in size. The 5- and 10-year survival rates were 22% and 8%, respectively, for the entire group of 107 patients, and 49% and 17%, respectively, for the 32 patients with tumors <5 cm. There were no operative deaths or major complications. These results demonstrate that cryosurgery is a useful treatment for primary liver cancer and results in long-term survival of a significant percentage of patients. Patients with tumors <5 cm in size benefit the most from this treatment.

Other treatment options for hepatocellular carcinoma include orthotopic liver transplantation, chemoembolization, HAI chemotherapy, and systemic chemotherapy.⁵⁴ Percutaneous intratumoral injection of 95% ethanol has also been shown to be effective for treatment of small (<3 cm or 4 cm) hepatocellular cancers.^{54,55} The ultimate role of cryosurgery in the treatment of this disease remains to be clarified.

Summary

Cryosurgery is a potentially curative treatment option for patients with unresectable liver metastases from colorectal cancer. It may also benefit carefully selected patients with other types of metastatic tumors. Other treatment options for patients with unresectable liver metastases are strictly palliative (HAI chemotherapy, systemic chemotherapy). Given the certain fatal outcome of hepatic metastases, cryosurgery offers an attractive alternative to palliative treatment. Cryosurgery is also an option for the treatment of primary liver tumors. Liver cryosurgery is a relatively new treatment and the indications are evolving

as more data become available. Further study will demonstrate the subset of patients who are most likely to benefit from this treatment. The role of adjuvant therapy (eg, HAI chemotherapy), in addition to cryosurgery, deserves further study.

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References

1. Parker SL, Tong T, Bolden S, Wingo PA. Cancer statistics, 1996. *CA Cancer J Clin.* 1996;65:5-27.
2. Blumgart LH, Fong Y. Surgical options in the treatment of hepatic metastasis from colorectal cancer. *Curr Probl Surg.* 1995;32:336-421.
3. Hughes K, Scheele J, Sugarbaker PH. Surgery for colorectal cancer metastatic to the liver. *Surg Clin North Am.* 1989;69:339-359.
4. Foster JH, Lundy J. Liver metastasis. *Curr Probl Surg.* 1981;18:157-202.
5. Scheele J, Stangl R, Altendorf-Hofmann A. Hepatic metastases from colorectal carcinoma: impact of surgical resection on the natural history. *Br J Surg.* 1990;77:1241-1246.
6. Adson MA, vanHeerden JA, Adson MH, Wagner JS, Ilstrup DM. Resection of hepatic metastases from colorectal cancer. *Arch Surg.* 1984;119:647-651.
7. van Ooijen B, Wiggers T, Meijer S, et al. Hepatic resections for colorectal metastases in The Netherlands. *Cancer.* 1992;70:28-34.
8. Savage AP, Malt RA. Survival after hepatic resection for malignant tumors. *Br J Surg.* 1992;79:1095-1101.
9. Iwatsuki S, Sheahan DG, Starzl TE. The changing face of hepatic resection. *Curr Probl Surg.* 1989;26:283-379.
10. Nordlinger B, Parc R, Delva E, et al. Hepatic resection for colorectal metastases: influence on survival of preoperative factors and surgery for recurrences in 80 patients. *Ann Surg.* 1987;205:256-263.
11. Ekberg H, Tranberg K-G, Andersson R, et al. Determinants of survival in liver resection for colorectal secondaries. *Br J Surg.* 1986;73:727-731.
12. Fortner JG, Silva JS, Golbey RB, Cox EB, Maclean BJ. Multivariate analysis of a personal series of 257 consecutive patients with liver metastases from colorectal cancer. *Ann Surg.* 1984;199:306-316.
13. Butler J, Attiye FF, Daly JM. Hepatic resection for metastases of the colon and rectum. *Surg Gynecol Obstet.* 1986;162:109-113.
14. Sesto ME, Vogt DP, Hermann RE. Hepatic resection in 128 patients: a 24-year experience. *Surgery.* 1987;102:846-851.
15. Wilson SM, Adson MA. Surgical treatment of hepatic metastases from colorectal cancers. *Arch Surg.* 1976;111:330-334.
16. Lind DS, Parker GA, Horsley JS III, et al. Formal hepatic resection of colorectal liver metastases. *Ann Surg.* 1992;215:677-684.
17. Steele G Jr, Bleday T, Mayer RJ, et al. A prospective evaluation of hepatic resection for colorectal carcinoma metastases to the liver: Gastrointestinal Tumor Study Group Protocol 6584. *J Clin Oncol.* 1991;9:1105-1112.
18. Gennari L, Doi R, Bignami P, Bozzetti F. Surgical treatment of hepatic metastases from colorectal cancer. *Ann Surg.*

1986;203:49-54.

19. Petrelli NJ, Nambisan RN, Herrera L, Mittelman A. Hepatic resection for isolated metastasis from colorectal carcinoma. *Am J Surg*. 1985;149:205-209.

20. Bradpiece HA, Benjamin IS, Halevy A, Blumgart LH. Major hepatic resection for colorectal liver metastases. *Br J Surg*. 1987;74:324-326.

21. Chang A, Schneider PD, Sugarbaker PH, et al. A prospective randomized trial of regional versus systemic continuous 5-fluorodeoxyuridine chemotherapy in the treatment of colorectal liver metastases. *Ann Surg*. 1987;206:685-693.

22. Martin JK, O'Connell MJ, Wieand HS, et al. Intraarterial floxuridine vs systemic fluorouracil for hepatic metastases from colorectal cancer. *Arch Surg*. 1990;125:1022-1027.

23. Kemeny N, Daly J, Reichman B, et al. Intrahepatic or systemic infusion of fluorodeoxyuridine in patients with liver metastases from colorectal carcinoma. *Ann Intern Med*. 1987;107:459-465.

24. Hohn DC, Stagg RJ, Friedman MA, et al. A randomized trial of continuous intravenous versus hepatic intraarterial floxuridine in patients with colorectal cancer metastatic to the liver: the Northern California Oncology Group Trial. *J Clin Oncol*. 1989;7:1646-1654.

25. Rougier P, Laplanche A, Huguier M, et al. Hepatic arterial infusion of floxuridine in patients with liver metastases from colorectal carcinoma: long term results of a prospective randomized trial. *J Clin Oncol*. 1992;10:1112-1118.

26. Petrelli N, Herrera L, Rustum Y, et al. A prospective randomized trial of 5-fluorouracil versus 5-fluorouracil and high-dose leucovorin versus 5-fluorouracil and methotrexate in previously untreated patients with advanced colorectal carcinoma. *J Clin Oncol*. 1987;5:1559-1565.

27. Erlichman C, Fine S, Wong A, Elhakim T. A randomized trial of fluorouracil and folinic acid in patients with metastatic colorectal carcinoma. *J Clin Oncol*. 1988;6:469-475.

28. Valone FH, Friedman MA, Wittlinger PS, et al. Treatment of patients with advanced colorectal carcinomas with fluorouracil alone, high-dose leucovorin plus fluorouracil, or sequential methotrexate, fluorouracil, and leucovorin: A randomized trial of the Northern California Oncology Group. *J Clin Oncol*. 1989;7:1427-1436.

29. Petrelli N, Douglass HO Jr, Herrera L, et al. The modulation of fluorouracil with leucovorin in metastatic colorectal carcinoma: a prospective randomized phase III trial. *J Clin Oncol*. 1989;7:1419-1426.

30. Poon MA, O'Connell MJ, Moertel CG, et al. Biochemical modulation of fluorouracil: evidence of significant improvement of survival and quality of life in patients with advanced colorectal carcinoma. *J Clin Oncol*. 1989;7:1407-1418.

31. Doroshow JH, Multhauf P, Leong L, et al. Prospective randomized comparison of fluorouracil versus fluorouracil and high-dose continuous infusion of leucovorin calcium for the treatment of advanced measurable colorectal cancer in patients previously unexposed to chemotherapy. *J Clin Oncol*. 1990;8:491-501.

32. Borgelt BB, Gelger R, Brady LW. The palliation of hepatic metastases: results of the Radiation Therapy Oncology Group pilot study. *Int J Radiat Oncol Biol Phys*. 1981;7:587-591.

33. Kinsella TJ. The role of radiation therapy alone and combined with infusion chemotherapy for treating liver metastases. *Semin Oncol*. 1983;10:215-222.

34. Webber BM, Soderberg CH, Leone LA, et al. A combined treatment approach to management of hepatic metastases. *Cancer*. 1978;42:1087-1095.

35. Lokich JJ, Kinsella T, Perri J, et al. Concomitant hepatic radiation and intraarterial fluorinated pyrimidine therapy: correlation of liver scan, liver function tests, and plasma CEA with tumor response. *Cancer*. 1982;48:2569-2574.

36. Lawrence TS, Dworzian LM, Walker-Andrews S, et al. Treatment of cancers involving the liver and porta hepatis with external beam irradiation and intraarterial hepatic fluorodeoxyuridine. *Int J Radiat Oncol Biol Phys*. 1991; 20:555-561.

37. Patt YZ, Mavligit GM. Arterial chemotherapy in the management of colorectal cancer: an overview. *Semin Oncol*. 1991;18:478-490.

38. Livraghi T. Ultrasound guided percutaneous ethanol injection therapy of hepatic tumors and metastases. *Z Gastroenterol*. 1993;31:260-264.

39. Hisa N, Ohkuma K, Fujikura Y, et al. Percutaneous ethanol injection therapy for hepatic tumors. *Seminars in Interventional Radiology*. 1993;10:27-33.

40. Masters A, Steger AC, Brown SG. Role of interstitial therapy in the treatment of liver cancer. *Br J Surg*. 1991;78:518-523.

41. Gage AA. Cryosurgery in the treatment of cancer. *Surg Gynecol Obstet*. 1992;174:73-92.

42. Steele G Jr, Ravikumar TS, Benotti PN. New surgical treatments for recurrent colorectal cancer. *Cancer*. 1990;65:723-730.

43. Ravikumar TS, Steele GD Jr. Hepatic Cryosurgery. *Surg Clin North Am*. 1989;69:433-440.

44. Ravikumar TS, Kane R, Cady B, et al. A 5-year study of cryosurgery in the treatment of liver tumors. *Arch Surg*. 1991;126:1520-1524.

45. Onik G, Rubinsky B, Zemel R, et al. Ultrasound-guided hepatic cryosurgery in the treatment of metastatic colon carcinoma. *Cancer*. 1991;67:901-907.

46. Charnley RM, Thomas M, Morris DL. Effect of hepatic cryotherapy on serum CEA concentration in patients with multiple inoperable hepatic metastases from colorectal cancer. *Aust N Z J Surg*. 1991;61:55-58.

47. Ravikumar TS, Kane R, Cady B, et al. Hepatic cryosurgery with intraoperative ultrasound monitoring for metastatic colon carcinoma. *Arch Surg*. 1987;122:403-409.

48. Ravikumar TS, Steele G Jr, Kane R, King V. Experimental and clinical observations on hepatic cryosurgery for colorectal metastases. *Cancer Res*. 1991;51:6326-6327.

49. Ravikumar TS, Buenaventura S, Salem RR, D'Andrea B. Intraoperative ultrasonography of liver: Detection of occult liver tumors and treatment by cryosurgery. *Cancer Detect Prev*. 1994;18:131-138.

50. Weaver ML, Atkinson DP, Zemel R. The treatment of unresectable hepatic metastases with cryosurgery. Presented at the Annual Meeting of the Society of Surgical Oncology; March 21-24, 1996; Atlanta, GA.


51. Preketes AP, Caplehorn JRM, King J, Clingan PR, Ross WB, Morris DL. Effect of hepatic artery chemotherapy on survival of patients with hepatic metastases from colorectal carcinoma treatment with cryotherapy. *World J Surg*. 1995;19:768-771.

52. Ravikumar TS, Zamek R, D'Andrea B, Gopal S, Goel R. Cryoablation and hepatic arterial infusion for colorectal liver metastasis: a phase I/II trial. Presented at the Annual Meeting of the Society of Surgical Oncology; March 21-24, 1996; Atlanta, GA.

53. Zhou X-D, Tang Z-Y, Yu Y-Q et al. The role of cryosurgery in the treatment of hepatic cancer: a report of 113 cases. *J Cancer Res Clin Oncol*. 1993;120:100-102.

54. Venook AP. Treatment of hepatocellular carcinoma: too many options? *J Clin Oncol*. 1994;12:1323-1334.

55. Livraghi T, Bolondi L, Lazzaroni S et al. Percutaneous ethanol injection in the treatment of hepatocellular carcinoma in cirrhosis. *Cancer*. 1992;69:925-929.



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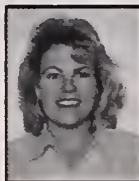
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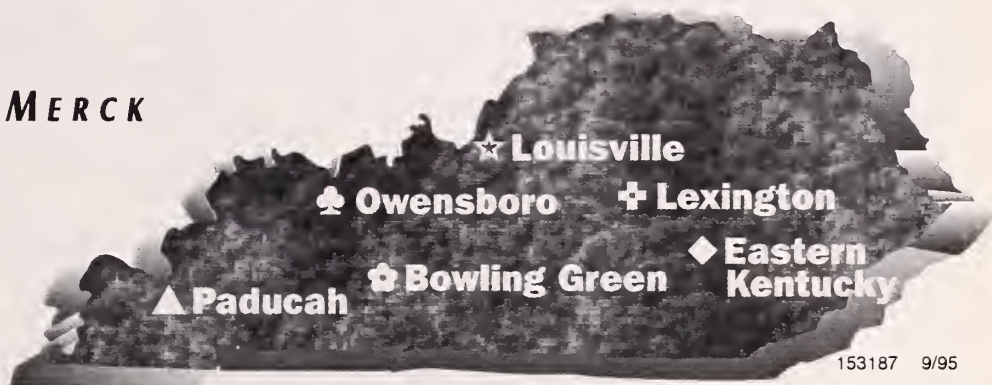


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ECT-Induced Seizure Durations

Scott Haas, MD; Kenneth Nash, MD; Steven B. Lippmann, MD

Electroconvulsive therapy (ECT) efficacy is related to the stimulus intensity and clinically associated with the duration of the induced seizure. Convulsions lasting 30 to 60 seconds are conventionally considered to be of optimal length, and generally are achieved by applying routine ECT technique. An ictus slightly shorter or longer is usually also therapeutically satisfactory.

In our study, seizures lasting between 30 and 60 seconds produced a favorable clinical outcome. A very similar effect was observed in all cases where the duration was within 16 to 120 seconds. However, subjects experiencing ictal periods of less than 15 seconds and those over 120 seconds resulted in less favorable response. Detailed records as to medicinal and electrical stimulus doses, seizure timings, etc, were excellent guides for subsequent ECT to achieve appropriate convulsion durations and a safe, satisfactory outcome.

House Officer interest in electroconvulsive therapy (ECT) determinations of stimulus intensity settings precipitated a plan to study ECT-induced seizure durations as correlated to therapeutic efficacy and side-effects. Research was initiated early in this decade to review our ECT experience. We had clinical data on several years of ECT administration done in a routine hospital setting. This material included treatment parameters, outcome impressions, and records on sequelae. A literature survey was followed by an analysis of the results of our ECT practice.

Electroconvulsive therapy induces ictal periods in somewhat predictable patterns.^{1,3} Therapeutic efficacy may be associated with the degree to which the electrical stimulus energy exceeds the seizure threshold.⁴ Electrical dose and clinical response are related to the length of the seizure. Using the duration of the convulsion, stimulus parameters are set to deliver the least suprathreshold dose compatible with an optimal result. On a clinical basis, effective seizures are deemed to continue beyond 25 seconds, but under 2 minutes.⁴⁻¹⁰ Stimulus intensity must be above threshold enough to evoke such seizure durations.¹⁰

Optimal convulsion times conventionally are considered to last between 30 and 60 seconds, but the exact range remains less clearly determined.^{1,3,6,9} An ictal event protracted well beyond one minute should produce improvement in mood, but may be less desirable because of a higher potential for memory disturbance.^{5,11} The risk/benefit ratio shifts so that the cognitive dysfunction might outweigh the therapeutic mood enhancement. Seizures shorter than one half minute, on the other hand, may be less efficacious by producing inadequate clinical responses. There is also evidence to indicate that stimulus intensity, ictal length, and treatment outcome may not always have a reliable relationship.^{4,6} These clinical parameters were to be the focus of our study.

Method

A retrospective study of all 608 ECT treatments done from 1987 through mid-1990 was performed recording the seizure duration of each instance. The electrical dosage for each patient was individualized by age and sex. The initial energy parameters were selected based on a formula recommended by the ECT machine manufacturer (Table 1).¹² Electrode placement was at standard bifrontotemporal locations. ECT was bilaterally administered using a Mecta SR-1, type B, (Mecta Corporation, Portland, Oregon) constant current, bidirectional square wave, brief pulse stimulus. All subsequent electrical dosages were altered

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Table 1. Common Initial Brief Pulse ECT Dose Range Parameters

| Patient | Pulse Width (m sec) | Frequency (Hz) | Duration (sec) | Current (Amps) |
|---------------------|---------------------|----------------|----------------|----------------|
| Female under age 30 | 1.4 | 70 | 1.25 | 0.8 |
| Female 30-60 years | 1.4 | 80 | 1.25 | 0.8 |
| Female over age 60 | 1.4 | 80 | 1.5 | 0.8 |
| Male under age 30 | 1.4 | 80 | 1.5 | 0.8 |
| Male 30-60 years | 1.4 | 90 | 1.5 | 0.8 |
| Male over age 60 | 1.4 | 90 | 2.0 | 0.8 |

ECT-Induced Seizure Durations

Table 2. Ictal Duration of Each ECT Session

| <15 sec | >120 sec | 30-60 sec | 16-29 sec | 61-120 sec |
|---------|----------|-----------|-----------|------------|
| 29 | 25 | 359 | 76 | 201 |
| 4% | 4% | 52% | 11% | 29% |
| | | | 92% | |

Total = 690, which is greater than 608 treatments due to some patients receiving more than one ECT at a given session when the convulsion duration was brief.

Table 3. Ictal Duration by Clinical Response

| Efficacy | <15 sec | >120 sec | Both <15+>120 sec | 15-120 sec |
|----------|---------|----------|-------------------|------------|
| Good | 7 | 4 | 3 | 35 |
| Fair | 2 | 2 | 3 | 8 |
| Poor | 1 | 1 | 1 | 1 |

on the basis of previous individualized, clinical experiences. The duration of each person's last seizure was used to set the following session's stimulus intensity.

When seizure times of less than 30 seconds were observed, the following ECT was done with hyperventilation at a higher electrical setting. Occasional further ictal augmentation included stimulation in 16 sessions with a Medcraft B-24 (Electronic Corporation, New York), constant voltage, sine-wave apparatus, and 14 instances of pretreatment IV caffeine. The latter two techniques were only applied if hyperventilation and maximum brief pulse electrical stimuli (ie, 2 mSec, 90 Hz, 2 Sec and 0.8 Amps) failed to produce a 30 second ictus. The sine-wave method was utilized prior to 1989; after that, seizure enhancement was provided via caffeine infusions.

Anesthetic management included IV pharmaceuticals and controlled ventilation using 100% oxygen by mask. Glycopyrrolate, 4.4 ug/kg was infused just prior to the procedure. Anesthesia was induced with Methohexital, 0.8 – 1.0 mg/kg after preoxygenation. Succinylcholine 0.8 – 1.0 mg/kg afforded muscular relaxation.

The length of each ECT seizure was recorded, with the duration monitored by single channel electroencephalogram (EEG). The EEG tracing was from the left hemisphere, with one lead placed just left of the midline on the forehead, one inch above the left eyebrow, and the other one behind the ear, one inch above the left mastoid process. A convulsion was arbitrarily

designated as prolonged if an EEG-documented ictal event lasted beyond 120 seconds. A brief seizure reflects under 15 seconds of ictal activity. Convulsions lasting 61 to 120 seconds or those between 15 and 29 seconds are not categorized here as either prolonged or as brief events. Ictal times in the 15 to 29 second range were not a cause for concern; longer convulsions, at between 61 and 120 seconds sometimes may create more memory dysfunction, but efforts at diminishing subsequent seizure times were only made, if clinically warranted, as in cases of excessive posttreatment confusion.

Response to ECT was, in a non-blinded manner, based on a global clinical impression by the attending physician (SL), who received postgraduate training in ECT practice and EEG interpretation. Outcome focused on mood-related aspects of the case. Ictal durations were determined by this clinician's reading of the EEG record, from stimulus offset until onset of postictal suppression. Reliability of EEG readings, including recognition of seizure end-point, was confirmed in 10 randomly selected cases by another ECT practitioner and by an independent electroencephalographer.¹³

Results

There were 608 ECT sessions involving 68 individual patients. There were 47 females and 21 males. Five subjects were African-American, while the rest were Caucasian. The mean age was 44 with a range of 18 to 87. There were 25 instances of a prolonged ictal (ie, >120 seconds) and 29 categorized as being brief (ie, <15 seconds). Table 2 illustrates the duration of all ECT seizures. Convulsion times are charted in Table 3 with respect to clinical response.

Discussion

In a review of 608 ECT sessions spanning a 3 1/2 year period, good therapeutic results with seizure durations at conventionally recommended lengths of time were observed. Convulsions, usually lasting between 15 and 120 seconds, resulted from use of routine protocol and electrical dosages. Most seizures were even within the narrower range of 30 to 60 seconds, perhaps the most theoretically optimal timing. Outcome was gratifying and side-effects were nil.

Initial ECT stimuli were performed at or near manufacturer suggested electrical parameters,

based on patient age and sex.¹² Follow-up settings were selected to achieve convulsion times aimed at between 30 and 60 seconds. Hyperventilation and stimulus dose adjustments usually resulted in lengthening seizures. In those occasional exceptions when still further ictal augmentation was indicated, pretreatment caffeine or sine-wave ECT was successfully employed. The caffeine method of seizure threshold reduction is, since 1989, our favored technique.

In cases when convulsions were longer than desired, there were no sequelae and a good outcome as well. Protracted ictus was usually managed by future stimulus dosage reductions. Prolonged seizures were sometimes terminated by IV administration of Pentothal. In virtually all cases, use of the above technique resulted in bringing most induced convulsions into acceptable time ranges. Even in the exceptions, there were no major problems and no sequelae.

Documents reflecting *all* previous sessions were maintained at the ECT administration site. Past ECT records were consulted on each patient receiving beyond their first treatment. Information included dates, stimulus parameters, electrode placements, complications and suggestions for future applications, etc. Setting electrical and medicinal doses followed a review of that patient's past treatments. Such records were of great help in maintaining optimal seizure durations.

In this study of 68 people who received ECT, there were only 4 persons recorded to have had a suboptimal clinical response. Satisfactory convulsion duration cases experienced favorable therapeutic results, with only one exception. Two of the poor outcome subjects had received treatments resulting in an ictal period of <15 seconds or >120 seconds. Amongst the 44 individuals with 15 to 120 second seizure spans, 35 had a good clinical outcome, 8 were described as fair, and there was one with poor results. This is a good:fair:poor ratio of 35 to 8 to 1. Response was gratifying.

In those ECT sessions producing <15 second seizure intervals, results were less favorable. Seven people had a good effect, 2 showed fair improvement, and 1 had a poor response. The good:fair:poor enumeration declined at 7 to 2 to 1. Males were disproportionately often experiencing these shorter seizure timings, perhaps as a reflection of greater electrical impedance. Higher stimulus doses are required in men. Considering response in subjects with the >120 second seizures, 4 were good, 2 showed fair progress, and

1 was in the poor group. Therefore, the good:fair:poor ratio fell further to 4 to 2 to 1. ECT ictal timing cases lasting <15 seconds or >120 were noted to have derived optimal clinical effectiveness *less* frequently. Good outcome occurred much more often in those patients with a convulsion consistently lasting between 15 and 120 seconds. Such seizure durations clinically appear to be the most desirable in length, but how clearly response and ictal period is related remains less certain.

This small study suggests a positive benefit to inducing ECT seizure times within conventionally recommended durations. Monitoring the length of the convulsion should allow selection of the most appropriate energy level necessary for subsequent ECT sessions. Following routine protocol usually produced a convulsion within suggested time limits, with 52% being in the theoretically optimal period of 30 to 60 seconds. Some seizures lasted just beyond this interval, with 70% of them between 25 and 75 seconds, and 92% were in the range of 15 to 120 seconds. The latter individuals' clinical responses were *indistinguishable* from the 30 to 60 second ictal timing cases. Declaring an optimal ECT convulsion duration is therefore somewhat arbitrary, since outcome is similar within broader ranges of 15 to 120 seconds, or the more narrow recommendations of 30 to 60 seconds. Aiming to be within these guidelines is a practical goal, since a gratifying ECT-induced response with few adverse consequences can be anticipated.

Seizure Timing with ECT

Convulsion duration can be influenced by alterations in the seizure threshold. Raising the threshold, at a constant stimulus intensity, would shorten the ictal period, while lowering it should lengthen the timing. There are many physical and pharmacological factors which change the seizure threshold, therefore, there is a wide range in the electrical dosage needed for ECT.^{4,5}

Anything raising ictal thresholds plays a role in ECT practice because of the potential for a shorter seizure.¹⁴ Examples include the aging process, dehydration, and certain medications, such as sedatives and anticonvulsants. Repeated ECT over a short time period has a similar effect.^{4,8,14-16} Bilateral ECT requires a higher energy level than unilateral applications.^{4,5} Males need a higher stimulus dose than females. Contrarily, seizure thresholds are reduced by other drugs

ECT-Induced Seizure Durations

like xanthines, neuroleptics or antidepressants; certain withdrawal states, as in alcohol abstinence syndrome; and by preexisting convulsive tendencies, as in epilepsy or various metabolic disorders.¹⁷

Whenever ECT produces a suboptimal ictal duration, there are various techniques to lengthen the seizure. Applying an increase in the electrical dosage is the most common method. A more intense stimulus is usually effective at extending convulsion times; however, during an ECT series with shortened seizures or in a person also taking anticonvulsant medications, for example, even increasing the electrical parameters may not produce the desired results. There are also techniques to lower the seizure threshold. Hyperventilation provides increased oxygenation and reduces carbon dioxide to create an acute respiratory alkalosis which results in neuronal hyperirritability. Pharmacological interventions, too, can decrease seizure threshold. The xanthine drugs, like caffeine, enhance convulsive tendencies via adenosine A1 receptor inhibition.¹⁷ Administering pretreatment, intravenous (IV) caffeine is a good ECT method of ictal augmentation, by inducing transient seizure threshold reductions.^{11, 14, 16, 18} Otherwise, when the convulsion durations are longer than desired, reducing the stimulus energy at the next session usually produces more satisfactory seizure timings.

References

1. Crowe R. Electroconvulsive therapy — A current perspective. *N Engl J Med*. 1984;311:163-166.
2. Gaines G, Rees I. Electroconvulsive therapy and anesthetic consideration. *Anesth Analg*. 1986;65:1345-1356.
3. Selvin BL. Electroconvulsive therapy — 1987. *Anesthesiology*. 1987;67:367-381.
4. Sackeim H, Decina P, Prohovnik I, Malitz S. Seizure threshold in electroconvulsive therapy. *Arch Gen Psychiatry*. 1987;144:355-360.
5. Weiner R. ECT and seizure threshold: Effects of stimulus wave focus and electrode placement. *Biol Psychiatry*. 1980;15:225-241.
6. Fink M, Johnson J. Monitoring the duration of electroconvulsive therapy seizures 'cuff' and EEG methods compared. *Arch Gen Psychiatry*. 1982;39:1189-1191.
7. Greenberg L. Detection of prolonged seizures during electroconvulsive therapy: A comparison of electroencephalogram and cuff monitoring. *Convulsive Therapy*. 1985;1:32-37.
8. Coffey C, Weiner R, Hinkle P. Augmentation of ECT seizures with caffeine. *Biol Psychiatry*. 1987;22:637-649.
9. Fink M. An adequate treatment? *Convulsive Therapy*. 1989;5:311-313.
10. Fink M. Energy parameters of ECT devices need reassessment. *The Psychiatric Times*. 1990;5:23-26.
11. Shapira B, Lerer B, Dror Gilboa, Drexler H, Kuglemass S, Calev A. Facilitation of ECT by caffeine treatment. *Am J Psychiatry*. 1987;144:1199-1202.
12. Mecta Corporation Instruction Manual, Sr and Jr Models, 1985.
13. Couture L, Lucas L, Lippmann S, Shaltout T, Paloheimo M, Edmonds H. Monitoring seizure duration during electroconvulsive therapy. *Convulsive Therapy*. 1988;4:206-213.
14. Hinkle P, Coffey C, Weiner R. Use of caffeine to lengthen seizures in ECT. *Am J Psychiatry*. 1987;144:1143-1147.
15. Sackeim H, Decina P, Prohovnik I. Dosage, seizure threshold, and the antidepressant efficacy of electroconvulsive therapy. In: Malitz M, Sackeim H, eds. *Electroconvulsive Therapy: Clinical and Basic Research Issues*. Annals of Academy of Science; 1986:398-410.
16. Shapira B, Zohar J. Potentiation of seizure length and clinical response to electroconvulsive therapy by caffeine pretreatment: A case report. *Convulsive Therapy*. 1985;1:58-60.
17. Kaufman K, Finstead R, Kaufman E. Status epilepticus following electroconvulsive therapy. *Mt Sinai J of Med*. 1986;53:119-122.
18. Coffey C, Figiel G, Weiner R, Saunders W. Caffeine augmentation of ECT. *Am J Psychiatry*. 1990;5:579-585.

The Prevalence of Genetic Disorders, Birth Defects and Syndromes in Central and Eastern Kentucky

Ronald G. Cadle, MS; Tasha Dawson; Bryan D. Hall, MD

Without an operative Birth Defects Registry, the state of Kentucky does not have a means of determining which of the nearly 6,000 syndromes and birth defects are the most common or the most rare, nor is there an ability to compare and contrast these data with data from other states. The authors reviewed 4,212 charts of patients evaluated between July 1981 and February 1995 by the Division of Genetics and Dismorphology at the University of Kentucky Chandler Medical Center. Each patient's chart was categorized by diagnosis, and tables were generated to determine the most common diagnoses in the following groups: (1) multiple congenital anomaly syndromes, (2) teratogenic embryopathies, (3) chromosome anomalies, (4) isolated malformations, and (5) bone dysplasias. The most common multiple congenital anomaly syndromes were Down syndrome, Marfan syndrome, and trisomy 18. Fetal alcohol syndrome and infants of diabetic mothers were the most common embryopathies. Spina bifida (meningocele and myelomeningocele) was by far the most common isolated birth defect, followed by cleft lip/palate and microcephaly. Achondroplasia was the most common bone dysplasia. These data support a number of previous assumptions including the universally high frequency of syndromes like Down syndrome and trisomy 18. The data also give credence to what was previously thought, but unproven, to be a high incidence of diabetic and alcohol embryopathies. The latter (fetal alcohol syndrome) has increased in frequency tremendously over the past 7 years. This is undoubtedly due in part to the overall increased awareness of the diagnosis in the medical community. However, it may also be due to the increased use of alcohol among Kentucky women. Other "rare" disorders, like diastrophic dysplasia, seem to be unusually common in central and eastern Kentucky.

Individually, genetic disorders, birth defects, and syndromes are relatively rare. Congenital heart defects represent the most common group of birth defects, with an incidence of one in 200.¹ Down syndrome, the most common multiple congenital anomaly syndrome, occurs in only one of every 600 births.² However, collectively, there are now described nearly 6,000 syndromes and birth defects³ with an overall occurrence rate of 3% to 4% in the general population.⁴ A knowledge of the prevalence of specific malformations and syndromes is important in determining those for which a specific population is at an increased risk. Additionally, this knowledge allows for the tracking of trends, such as dramatic increases in the incidence of any particular malformation over a given period of time in a specific geographic area. When trends are noted, potential explanations may be proffered, and interventions initiated. Currently, a statewide Birth Defects Registry is not operational in Kentucky, so that these type of data are not readily accessible.

There are two Clinical Genetics and Dismorphology Centers in Kentucky: (1) the Child Development Center associated with the University of Louisville, and (2) the Division of Genetics and Dismorphology in the Department of Pediatrics at the University of Kentucky Chandler Medical Center. The former provides genetic counseling and diagnostic services for the western part of the state, while the latter serves central and eastern Kentucky.

Materials and Methods

From July 1981 to February 1995, 4,212 patients were evaluated by the Division of Genetics and Dismorphology at the University of Kentucky Chandler Medical Center or at one of the affiliated regional genetic clinics in a variety of health de-

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Ms Dawson was a Senior Honar's student at Lexington's Henry Clay High School when this manuscript was in preparation. She completed the clinical research described in this paper, reviewing 4,212 patient charts.

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Prevalence of Genetic Disorders, Birth Defects and Syndromes

partments in eastern Kentucky. Each genetic chart was reviewed, and a final diagnosis tallied. Only "definite" or "probable" diagnoses were tallied into a specific category. If a diagnosis was considered only "possible," or was considered to be a "rule out" diagnosis, then it was placed into an unknown category. There were several unknown categories, including unknown multiple congenital anomaly syndromes (for those patients with a specific pattern of anomalies not recognized as a known syndrome), unknown neurologic/neuromuscular disorders, unknown bone dysplasias, and mental retardation/developmental delays of unknown etiology. A separate category simply called "unknown" included those patients who had several unique physical features, but did not have mental retardation, developmental delays, neurologic signs, or abnormal bones. In general, these patients were not so distinctly unusual as to suggest a syndrome. Another category was used to include individuals or couples being seen for preconceptional genetic counseling. These individuals generally had a family history of a genetic disorder or birth defect and sought information about their risk of having a similarly affected child in the future. These cases were tallied into a category termed "Genetic Counseling."

Results

Tables 1 through 7 summarize the findings of this study. "Genetic Counseling" was the most common overall diagnosis (485 patients), accounting for 11.5% of the 4,212 patients evaluated. "Unknown" (434) and "Unknown Multiple Congenital Anomaly Syndrome" (418) were the next most common diagnoses. These were followed by the

category termed "Normal" (302). Normal was used to indicate a patient who had no abnormal findings. Not surprisingly, Down syndrome is the most common multiple congenital anomaly syndrome in central and eastern Kentucky (191). This was followed by Marfan syndrome (44) and trisomy 18 (29). The most common teratogenic embryopathies were fetal alcohol syndrome (27), infants of diabetic mothers (23), and fetal hydantoin (Dilantin) syndrome (10). Following Down syndrome and trisomy 18 in the category of chromosome anomalies were Prader-Willi syndrome (23), Fragile X syndrome (20), Turner syndrome (14), and trisomy 13 (11). Spina bifida was by far the most common isolated malformation (109), followed by cleft lip/palate (44) and microcephaly (35). Among bone dysplasias, achondroplasia was the most common known diagnosis (37). Table 7 summarizes the relative frequency of the most common *specific* genetic disorders, birth defects, and syndromes, *excluding* all unknown and general categorical diagnoses.

Table 2. Most Common Multiple Congenital Anomaly Syndromes

| | | | |
|---|---------------------------|-----|----|
| 1 | Down syndrome | 191 | C |
| 2 | Marfan syndrome | 44 | AD |
| 3 | Trisomy 18 | 29 | C |
| 4 | Fetal alcohol syndrome | 27 | T |
| 5 | Noonan syndrome | 24 | AD |
| 6 | Infant of diabetic mother | 23 | T |
| | Prader-Willi syndrome | 23 | C |
| | Ectodermal dysplasia | 23 | XL |
| 9 | Osteogenesis imperfecta | 22 | AD |
| | Patter sequence | 22 | S |

C = Chromosomal

AD = Autosomal dominant

XL = X-linked

T = Teratogenic

S = Sporadic

Table 1. Most Common Diagnoses Overall

| | | |
|----|-------------------------------|-----|
| 1 | Genetic counseling | 485 |
| 2 | Unknown | 434 |
| 3 | Unknown MCA* syndrome | 418 |
| 4 | Normal | 302 |
| 5 | Down syndrome | 191 |
| 6 | Spina bifida | 109 |
| 7 | Neurofibromatosis, type I | 98 |
| 8 | Developmental delay, isolated | 79 |
| 9 | Unknown neurologic disorder | 70 |
| 10 | Marfan syndrome | 44 |
| | Cleft lip/palate | 44 |

* = multiple congenital anomaly

Table 3. Most Common Teratogenic Diagnoses

| | | |
|---|-------------------------------------|----|
| 1 | Fetal alcohol syndrome | 27 |
| 2 | Infant of diabetic mother | 23 |
| 3 | Fetal hydantoin (Dilantin) syndrome | 10 |
| 4 | Maternal PKU effects | 6 |
| 5 | Fetal valproate syndrome | 5 |
| 6 | Fetal alcohol effects | 3 |
| 7 | Cocaine embryopathy | 1 |
| | Valiue embryopathy | 1 |
| | Warfarin embryopathy | 1 |

Table 4. Most Common Chromosomal Abnormalities

| | | |
|----|---------------------------------------|-----|
| 1 | Down syndrome (trisomy 21) | 180 |
| 2 | Trisomy 18 | 29 |
| 3 | Prader-Willi syndrome (15q deletion) | 23 |
| 4 | Fragile X syndrome* | 20 |
| 5 | Turner syndrome | 14 |
| 6 | Trisomy 13 | 11 |
| 7 | Down syndrome (translocation) | 7 |
| 8 | Klinefelter syndrome | 6 |
| | Turner mosaic | 6 |
| 10 | Smith-Magenis syndrome (17p deletion) | 4 |

* = Not a true chromosomal disorder

Table 5. Most Common Isolated (Non-syndromic) Anomalies

| | | |
|----|------------------|-----|
| 1 | Spina bifida | 109 |
| 2 | Cleft lip/palate | 44 |
| 3 | Microcephaly | 35 |
| 4 | Arthrogryposis* | 25 |
| 5 | Macrocephaly | 24 |
| | Craniosynostosis | 24 |
| 7 | Encephalocele | 22 |
| 8 | Limb deficiency | 16 |
| 9 | Hydrocephalus | 14 |
| 10 | Pectus excavatum | 10 |

* = Categorical diagnosis

Discussion

This study indicates that Down syndrome is the most common multiple congenital anomaly syndrome in our population, a conclusion reached by other similar investigations in other states.^{5,6,7} Down syndrome accounts for 4.5% of all diagnoses in central and eastern Kentucky. Not surprisingly, the most common isolated malformation was myelomeningocele/meningocele (spina bifida). It has been estimated that neural tube defects (including spina bifida, encephaloceles, and anencephaly) occur once in every 500 births in Kentucky. This is twice as frequent as the overall United States incidence.⁸ The most likely explanation for this increased frequency is based on the ancestry of the people of central and eastern Kentucky which is largely English, Irish, Scotch, and/or Welsh. The incidence of neural tube defects in England, Ireland, Scotland, and Wales is higher than any other country in the world.^{9,10} It should be noted that the Division of Genetics and Dysmorphology evaluates only a small percentage of children with certain isolated defects such as congenital heart

defects and urinary tract defects. These types of isolated anomalies are therefore under-represented in this study, which is why they do not appear on the list of most common isolated malformations.

In 1986, an informal and unpublished review of the diagnoses made at the University of Kentucky Division of Genetics and Dysmorphology revealed very few patients with fetal alcohol syndrome (FAS). As a matter of fact, FAS was not even among the 30 most common diagnoses at that time. However, in the study reported here, it is the *fourth* most common multiple congenital anomaly syndrome, and *the* most common teratogenic diagnosis. This dramatic increase is probably due to two factors: (1) Increased use of alcohol by Kentucky women, and (2) increased awareness of the adverse effects of alcohol by those who refer patients to genetics clinics. The number of patients who are referred to rule out FAS have increased dramatically over the past

Table 6. Most Common Bone Dysplasias

| | | |
|---|---------------------------------------|----|
| 1 | Unknown bone dysplasia | 37 |
| 2 | Achondroplasia | 11 |
| 3 | SED, congenita* | 10 |
| 4 | Diastrophic dysplasia | 8 |
| 5 | Ellis van Creveld syndrome | 6 |
| 6 | Dyschondrosteosis of Leri and Weill | 5 |
| 7 | Thanatophoric dwarfism | 4 |
| 8 | Camptomelic dysplasia | 3 |
| 9 | Achondrogenesis | 2 |
| | Jeune asphyxiating thoracic dystrophy | 2 |
| | Hypochondroplasia | 2 |
| | Hypophosphatasia | 2 |
| | Metatropic dysplasia | 2 |

* = Spondyloepiphyseal dysplasia, congenita

Table 7. Most Common Specific Diagnoses Overall (Including Multiple Congenital Anomaly Syndromes Isolated Anomalies and Genetic Disorders)

| | | |
|----|----------------------------|-----|
| 1 | Down syndrome | 191 |
| 2 | Spina bifida | 109 |
| 3 | Neurofibromatosis, type I | 98 |
| 4 | Marfan syndrome | 44 |
| | Cleft lip/palate | 44 |
| 6 | Microcephaly, isolated | 35 |
| 7 | Trisomy 18 | 29 |
| 8 | Fetal alcohol syndrome | 27 |
| 9 | Arthrogryposis | 25 |
| 10 | Noonan syndrome | 24 |
| | Macrocephaly, isolated | 24 |
| | Craniosynostosis, isolated | 24 |

Prevalence of Genetic Disorders, Birth Defects and Syndromes



Fig 1 — Newborn infant of diabetic mother. Note femoral and tibial hypoplasia with bilaterally intorted feet. Also note polydactyly of the left foot. This patient also had ear anomalies, cleft palate and a heart defect, all common anomalies in infants born to women with poorly controlled diabetes.

several years. The second most common teratogenic diagnosis is IDM (infants of diabetic mothers). Women who have poorly controlled diabetes run an 8% risk of having a baby with any of a number of malformations.¹¹⁻¹⁴ These malformations include, but are not limited to: heart defects; ear anomalies; clefts of the lip and palate; vertebral defects; radial, tibial and/or femoral hypoplasia; neural tube defects; and many others (Fig 1).

It is interesting to note that there were 29 instances of trisomy 18, but only 11 cases of tri-

somy 13. The incidence of trisomy 18 is thought to be about 1 in 3000, while that of trisomy 13 is 1 in 5000.¹⁵ Given these figures, one would expect 17 or 18 cases of trisomy 13 for 29 instances of trisomy 18. The reason for the discrepancy in this study is unknown.

It is unusual to find autosomal recessive disorders in a listing of the most common syndromes. As a rule, these disorders are much rarer in a population since the occurrence of an autosomal recessive disorder is dependent upon two carrier parents each donating a recessive gene to their child. Autosomal dominant disorders occur as a result of receiving just one abnormal gene, making them more common. In the eastern and central Kentucky population, one autosomal recessive disorder in particular is more common than expected — diastrophic dysplasia. This disorder is an autosomal recessive bone dysplasia, and occurred eight times in this study. The majority of patients with this disorder are from the same eastern Kentucky county. Consanguinity (marriages between blood relatives) could be confirmed in two cases. Consanguinity increases the risk for miscarriage, stillbirth, multifactorially inherited birth defects, and autosomal recessively inherited birth defects and syndromes. The increased incidence of diastrophic dysplasia is due in part to consanguinity. Furthermore, the increased incidence of other malformations and syndromes in central and eastern Kentucky may also be due in part to consanguinity. It is estimated that 7% of all patients seen in the Genetics clinic at the University of Kentucky have parents who are consanguineous (Unpublished data, University of Kentucky, Division of Genetics and Dismorphology).

It is hoped that this study will increase awareness of the most common birth defects and syndromes in central and eastern Kentucky, and that it will serve as a reminder of the types of conditions which constitute appropriate referrals to a genetics clinic. Additionally, this type of study is instructive to physicians and other health care personnel in that it alerts these professionals to the syndromes, genetic disorders, and birth defects about which they should have more detailed knowledge. It should be understood, though, that this type of study does not accurately reflect all infants born in this geographic region of Kentucky. Miscarried fetuses, stillborn infants, and babies who die in the newborn period who have birth defects are often not evaluated by a geneticist, and are therefore not reflected in a study of

the nature reported here. Only a formal reporting tool such as a statewide birth defects registry can provide data which includes these types of patients.

References

1. Ferencz C, Rubin JD, McCarter RJ, et al. Congenital heart disease: Prevalence at live birth. *Am J Epidemiol.* 1985; 121:31-36.
2. Jones KL, ed. *Smith's Recognizable Patterns of Human Malformation*. 4th ed. Philadelphia, PA: W.B. Saunders;1988:10-15.
3. McKusick VA, ed. *Mendelian Inheritance in Man: Catalogs of Autosomal Dominant, Autosomal Recessive, and X-Linked Phenotypes*. 10th ed. Baltimore, MD: The Johns Hopkins University Press;1992:xxi.
4. Aase JA. *Diagnostic Dysmorphology*. New York, NY: Plenum Medical Book Co;1990:7.
5. Hall BD. The twenty-five most common multiple congenital anomaly syndromes. In: Kaback MM, ed. *Genetic Issues in Pediatric and Obstetric Practice*. Chicago, IL: Year Book Medical Publishers, Inc;1981:141-150.
6. Jacobson PL, Olney AH, Sanger WG, Buehler BA. The twenty-five most common multiple congenital anomaly syndromes in Nebraska. *Neb Med J.* 1986;71:65-67.
7. Park S, Smith B, Stevenson-Vine L, Harms L. *Wisconsin Birth and Developmental Outcome Monitoring Program 1990 and 1991*. Madison: Center for Health Statistics, Division of Health, Department of Health and Social Services, 1992:36.
8. Thompson MW, McInnes RR, Willard HF. *Thompson and Thompson Genetics in Medicine*. Philadelphia, PA: W.B. Saunders;1991:355-357.
9. Owens JR, Harris F, McAllister E, West L. 19 year incidence of neural tube defects in area under constant surveillance. *Lancet.* 1981;i:1032-1035.
10. Carter CO, David PA, Laurence KM. A family study of major central nervous system malformations in South Wales. *J Med Genet.* 1968;5:81-92.
11. Grix A, Curry C, Hall BD. Patterns of multiple malformations in infants of diabetic mothers. In: Nyhan WL, Jones KL, eds. *Prenatal Diagnosis and Mechanisms of Teratogenesis. Birth Defects Original Article Series*. New York, NY: Alan R. Liss, Inc; 1982;18(3A):55-77.
12. Neave C. Congenital malformations in offspring of diabetics. *Perspec Ped Path.* 1984;8:213-222.
13. Soler NG, Walsh CH, Malins JM. Congenital malformations in infants of diabetic mothers. *Q J Med.* 1976;45:303.
14. Day RE, Insley J. Maternal diabetes mellitus and congenital malformation. Survey of 205 cases. *Arch Dis Child.* 1976; 51:935.
15. Jones KL, ed. *Smith's Recognizable Patterns of Human Malformation*. 4th ed. Philadelphia, PA: W.B. Saunders;1988: 16-19; 20-25.

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Not Quite Like Buying a Refrigerator

I heard a patient complain one time that choosing a doctor or getting medical attention is not quite like buying a refrigerator. I really didn't mind the reverse metaphor once I knew she was not comparing my corpulent body with that of the eminent football player.

No. She really made a good point that got me thinking. In her description or analogy of shopping for that kitchen appliance she pointed out the ease of going to the store of her choice. There she would be met usually by a pleasant salesperson whose job it was to assist her in the choice.

The initial verbiage went something like, "May I help you?" The response to that could be "No, just looking thank you." Or more direct as, "Yes, I'm looking for a little something in my size of a refrigerator." Whereupon the salesperson would answer with either, "Please take your time," or else, "Right this way, please. We keep them over here on this side of the store."

So far things are going swimmingly. The customer (patient) is met by a pleasant warm body (secretary or office manager) who is going to assist her finding just what she is asking for. The initial word of "help" has already generated trust and a relaxing atmosphere. No need to step out of her clothes nor a request for some body fluids to be passed in a glass jar with an opening two inches in diameter.

But back to our script. The salesperson leads the way just a step ahead of the customer as they walk along firm flooring with very bright overhead lighting. No questions are being asked like, "What kind of insurance do you have?" and "How

old was your father when he died of dengue fever?"

Our shopping pair arrive at the large appliance area and there, lo and behold, are line upon line of new shiny refrigerators of varying sizes, colors, combinations, with freezers on top, bottom, or either side. It is a virtual cornucopia of choice. Not only that, each unit is marked with the total interior cubic feet, the cost to run it per kilowatt hour, and the price that includes delivery right to your kitchen. Just below that number is a notice that states "guaranteed" for 24 months. Now these large stickers are not put on the back or stuck away in a sliding produce drawer. No. These babies are virtually glued right on the front of the large swinging door for all to see. Why, I've never heard of such a thing!

In the lineup of these appliances, the price range can vary as to the size. If all that is needed is an auxiliary unit for one's garage to store hubby's Coors beer or last week's vat of vegetable soup, that is available. In fact it may even be on sale, or marked down.

On the other end of the spectrum one can find a walk-in freezer that will keep a steer even before he has been slaughtered. This one of course will have a lay-a-way plan to help finance the cost. Not only that, the customer might then say, "Thank you. Just looking," and travel a short distance to a competing store and start the whole rigamarole all over again, and no one is upset or salesperson felt put out by the time spent and no sale to show for it. But in the very end the customer knows precisely just what the cost will be, how soon delivery will be made, and how their household budget will finance it.

My story today is hardly meant to be a testimonial for sales and service of an "ice box," but more of a comparison to the diagnosis and treatment of any medical malady. Can't you just imagine the consternation and doubt that any uninformed patient would have in their search for medical attention? In a worst case scenario an ill person would be new in town and have no one (short of a taxi driver) to advise them as to where to go and whom to see.

The average physician, be he (she) a specialist or sub-specialist, does not have on his door a sign or plaque that states just what type of medicine they perform. And, heaven forbid, there is no greater turn-off for a receptionist to hear from a potential patient than, "I'm just looking for a doctor."

Well, the reader can see where this tiny essay is going. At this point the stereotypical patient has not even met the physician, and even if he goes next door he has no idea at all of the cost comparison or competence of Dr A. to Dr B. What he does know is that he does not want the economy model, and saving a few dollars here and there is not in his equation.

Now, and even in my more halcyon days before Medicare, I have never had a patient ask me, "Doctor, how much will all that cost me?" Sometimes, even I did not know.

Sad to say, but the average person will have three or at the most four refrigerators in a lifetime. Just think of how many physician visits one has from birth to death. Having a sharper pencil just won't help.

Milton F. Miller, MD

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- Equipment which will create noise must not be used during the general sessions and, at other times, must be controlled by head or earphones or a muffling device.
- Exhibit must be dismantled and removed by 12:00 AM, Sunday, September 29, 1996.
- Exhibit space is **strictly limited** to footage and space allotted. **No** exhibit may extend into the aisle.

Commonwealth Convention Center and the Kentucky Medical Association or its agents cannot guarantee against loss or damage and will assume no liability for damages nor guarantee the exhibitor against loss of any kind. The exhibitor agrees, with the Association, to be responsible to the Commonwealth Convention Center for damages that may occur as a result of the exhibitor's use of the facility.

Kentucky Medical Association Alliance

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It is with great pleasure that I introduce to Kentucky physicians and their spouses the 1996-1997 Board of Directors of the Kentucky Medical Association Alliance. Certainly you will join me in applauding the directors for their commitment of time and energy to a dynamic organization that touches the lives of many Kentucky citizens, both medical and non-medical.

Ruth Ryan
KMAA President



Ruth Ryan

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502/796-4108

The KMA Board of Trustees met in regular session on April 17-18, 1996, at Oxmoor Country Club in Louisville. The Board members heard reports from the President; Secretary-Treasurer; Alliance President; Dean, University of Kentucky College of Medicine; Board of Medical Licensure; Chair, KEMPAC Board of Directors; Delegate to the AMA; and the Commissioner, Bureau of Health Services.

An extensive report was presented summarizing activities during the 1996 Kentucky General Assembly; and the Board heard presentations from Lieutenant Governor Steve Henry, MD, and Secretary of Health Services John Morse focusing on physicians' concerns with UNISYS and Medicaid claims.

The Board adopted the budget for fiscal year 1996-97, and the Sponsorship Agreement between KMA and the KMA Insurance Agency, Inc. In further action, the Board appointed a member and alternate to serve on the SB 137 Advisory Board as requested by the Department of Agriculture; selected nominees for service on the Kentucky Board of Medical Licensure; and approved plans for the new Headquarters Office.

Legal Counsel updated the Board on current legal activities regarding the Medicaid lawsuit settlement.

Additional reports were given by the Ad Hoc Committee to Study Guidelines for Prescribing Controlled Substances, the Physician Organization Study Committee, the Interspecialty Council, the Committee on National Legislative Activities, the Public Education Committee, the Committee on Physical Education and Medical Aspects of Sports, and the Committee on Medical Insurance and Prepayment Plans.

The KMA Board of Trustees will hold its next regular meeting on August 14-15, 1996, at the Oxmoor Country Club. *KMA*



Spring KMA Board Meeting



Top photo — Board members, L to R, Harry W. Carlross, MD, Chair; Danny M. Clark, MD, President; William H. Mitchell, MD, President-Elect; C. Kenneth Peters, MD, Speaker; Donald R. Stephens, MD, Vice President.

At left, top — Lt Governor Steve Henry, MD; center — John Morse, Secretary of Health Services; bottom — Donald R. Neel, MD, KMA 2nd District Trustee.

Above, top — Preston P. Nunnelley, MD, Chair, Public Education Committee; bottom — Wally O. Montgomery, MD, Chair, State Legislative Activities Committee.

PEOPLE

David P. Rouben, MD, a partner in River City Orthopaedic Surgeons, Louisville, has been elected president of the medical staff of Columbia Southwest Hospital.

Billy F. Andrews, MD, U of L Department of Pediatrics, has been elected as a member of the Order of International Fellowship, *Pro bono publico*. A medal was awarded to Dr Andrews for his contributions to research, invention, and education in the field of neonatology, in pediatrics, and for contributions to the humanities in medicine.

Allan Tasman, MD, U of L Department of Psychiatry, was elected president-elect of the American Association of Chairmen of Departments of Psychiatry for 1995-96.

Allen H. Rees, MD, U of L Department of Pediatrics, recently served as a visiting professor in Chile where he gave a series of lectures related to the specialty of pediatric cardiology to residents, cardiovascular surgeons, and pediatric cardiologists at the Pontifical Catholic University Medical School.

(nonmembers \$29.95) by calling toll free 800/621-8335 and requesting Publication #OP205996.

Non order-related questions about the book should be directed to Mark J. Segal, PhD, Director of the Medical Practice Financing and Systems Unit, at 312/464-4726.

Pediatrician Combats Abuse

Jacqueline M. Sugarman, MD, a U of L emergency medicine pediatrician who examines sexually abused children at Louisville's Children First clinic in the Alliant Medical Pavilion, finds it easy to believe the disturbing, widely-cited statistics that one in four girls and one in seven boys are sexually abused before they reach the age of 18.

Although numbers citing the volume of child sexual abuse vary widely in the medical literature, Dr Sugarman says her work has convinced her that such abuse is more common than many want to believe.

According to information provided by the University of Louisville, the Children First clinic (a nonprofit agency not affiliated with U of L) last year examined more than 300 young suspected abuse victims from the Louisville area.

Since joining the clinic part time in 1993, Dr Sugarman says she has seen cases that have opened her eyes to the magnitude of the problem, and that sexual abuse of children crosses all socioeconomic levels and all strata of society.

"We have seen children ages 6 months to 18 years," she said. Dr Sugarman says psychological damage to a child from sexual abuse is usually greater than physical injury.

In fact, most sexually abused children show no physical injury. In their anguish to find a reason for the abuse, children often blame themselves. "We always reassure the children that they're normal, that it

wasn't their fault that this happened, that nobody blames them."

Along with doing medical exams at the Children First clinic, Dr Sugarman is researching improvements in the quality of physical exams on abused children. In one study, she and a colleague are studying unintentional injuries to girls' genitals, such as those caused by bike falls, to see if they are different from those resulting from sexual abuse.

This is important, Dr Sugarman said, because a defense lawyer in an abuse trial invariably will bring up the possibility of non-abuse injury. In another study, she and a co-investigator are comparing exam assessments from photographs with assessments performed in person to see if photos provide similar information.

About six times per year, Dr Sugarman is subpoenaed to testify in court about her exam findings. As a result of her work, Dr Sugarman has helped get children removed from abusive homes and abusers put in jail. Conversely, her exams have helped to disprove suspected cases of abuse.

Unfortunately, Dr Sugarman says, the caseload never ends.

"Smart" Machine May Improve Treatment of Sleep Apnea

The University of Louisville reports that a new "smart" machine may allow doctors more effectively to diagnose and treat sleep apnea, a medical condition that causes people to stop breathing intermittently during sleep.

Eugene C. Fletcher, MD, director of the Sleep Disorders Clinic at University of Louisville Hospital, is testing a new version of a common tool — the Continuous Positive Airway Pressure machine — both to identify and manage the condition. Instead of administering a constant stream of air, the new machine activates only when it senses that a

UPDATES
**Electronic Data Interchange:
The Physicians' Guide**

The AMA is now offering a publication entitled *Electronic Data Interchange: The Physicians' Guide*. The *Guide* was developed to familiarize physicians with the features, benefits, and challenges of EDI, and it provides a number of practical tools on EDI.

Copies of the *Guide* are available at the AMA member price of \$19.95

patient has stopped breathing.

The machine can be used at home; its breathing channels can be analyzed and the patient diagnosed in the physician's office instead of in a sleep disorders clinic.

Early Treatment is Key in Reducing Effects of Epilepsy

University of Louisville researchers may have settled the debate on whether to treat suspected incidents of epilepsy after the very first seizure or wait several months for a second seizure to confirm the diagnosis.

Neurology professor **Vasudeva G. Iyer, MD's**, team discovered in lab studies that administering medication early improved the chances of complete remission and reduced the number of seizures even after medication was stopped. If a medication program did not begin until after a second seizure, the number of epileptic incidents was reduced only during the medication program.

Remote Access to Medical Database Now Available at U of L

Medline is the preeminent citation and abstract database for research journals in the health sciences. Members of the U of L community no longer have to go to the Kornhauser Library or provide their own systems to search electronically the biomedical journal literature.

Kornhauser Library has set up an information display and a demonstration terminal on the database. It also has Medline packets for users interested in connecting to the system.

Produced by the National Library of Medicine, Medline provides access to information about more than 7.8 million articles published in 3,700 journals from 70 countries in more than 40 languages. Its print

counterparts are "Index Medicus," "Index to Dental Literature" and "International Nursing Index." The database was begun in 1966.

Ovid, the search software selected for use with Medline, provides a platform that can be expanded to support additional information services. Long-range plans call for the addition of other citation databases and expansion of the Ovid system to full-text journal databases.

Medline users can conduct literature searches from computer workstations in their offices or homes as well as in the libraries. Citations, indexing, and abstracts found in Ovid/Medline can be printed on an attached printer, downloaded to a floppy disk, e-mailed to a user's account or sent via file transfer protocol (FTP) to another computer.

Ovid provides a powerful and sophisticated search engine that complements search features provided by Medline, librarians say. Two search modes are available: "easy mode" and "full mode." Full mode provides the full range of professional searching features, including command searching, tree displays, and floating subheadings. Easy mode leads users through a series of steps to help them acquire the information they need.

Ovid also provides a unique "mapping" feature that allows users to obtain information from Medline's official headings by entering common terms. For example, typing "heart attack" as a search term will lead to the accepted subject heading, "myocardial infarction."

Access to Ovid/Medline is password-controlled and is available to U of L faculty, staff, and students. Information about connecting and searching is available at the reference desks of Kornhauser, Ekstrom, and Kersey libraries.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyd

Joseph George Bajorek, MD — N
2233 Montgomery Ave Ste B, Ashland
41101

1989, U of Miami
Ira Lee Harrell Jr, MD — S
PO Box 682, Louisa 41230
1990, U of S. Carolina

Daviess

Sheri W. Armstrong, MD — R
3681 Briarcliff Trce, Owensboro 42303
1990, U of Louisville

Robert L. Halterman, DO — FP
1215 Main St, Hartford 42347-9651
1988, U of Health Sciences,
Kansas City

David L. Harmon, DO — P
1000 Industrial Dr, Owensboro 42302
1989, U of Health Sciences,
Kansas City

Kenneth C. Henderson, MD — PD
Owensboro Mercy Health Systems,
Owensboro 42304-0007
1967, U of Louisville

Henderson

David I. Malitz, MD — OPH
7844 E Oak St, Evansville 47715
1987, U of California, Los Angeles

Jefferson

Wallace A. Askew, MD — OPH
1305 Wall St, Jeffersonville 47130
1966, U of Southern California,
Los Angeles

Paul D. Forrest, MD — NS
PO Box 714, Prospect 40059
1965, Tulane

William P. McKinney, MD — IM
8610 Cheffield Dr, Louisville
40222-5649

1978, U of Texas, Dallas
William L. O'Neill Jr, MD — S

225 Abraham Flexner Way Ste 700,
Louisville 40202
1987, St. Louis College of Physicians
Joyce A. O'Shaughnessy, MD — **ONC**

250 E Liberty St Ste 802, Louisville
40202
1982, Yale
Donna Fay Sadler, MD — **FP**
14011 Echo Hill Tr, Louisville 40299
1986, U of Louisville
Robert L. Schroering, DMD — **DENT**
3950 Kresge Way Ste 403, Louisville
40207-4637

1987, U of Louisville
Robert E. Wolf, MD — **ORS**
7617 Deer Meadow Dr, Louisville
40241
1989, U of Texas, Dallas

Johnson

Nagaraja An Rao, MD — **N**
713 Broadway, Paintsville 41240
1975, Kurnool, India

Letcher

Aban A. Affan, MD — **AN**
205½ Hale Dr, Whitesburg 41858
1982, Ain Shams, Egypt

McCracken

Van M. Woeltz, MD — **N**
5154 Village Square Dr, Paducah
42001
1990, U of Kentucky

In-Training

Jefferson

Jared K. Wilson, MD — **FP**

Kenton

Michael S. McLeod, MD — **FP**

DEATHS

Jane B. Sears, MD
Louisville
1927-1996

Jane B. Sears, MD, a retired internist, died April 26, 1996. Dr Sears graduated from Harvard Medical School in 1951 and was a life member of KMA.

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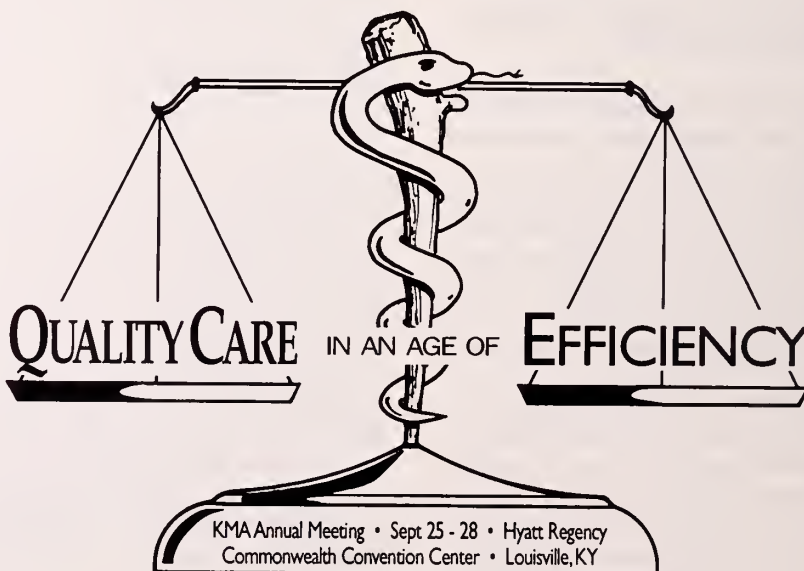
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American Medical Association's New "EVP"

People and Patients — his "foremost priority"

by Arnold Collins

If the position of Executive Vice President of the American Medical Association continues to be as demanding as it was under former EVP James S. Todd, MD, then P. John Seward, MD, should do well in it, or so say many who have known and worked with him and who call themselves "privileged" to be his friend.

The job of EVP is "an uncommon one," according to Dr. Todd, who held the office for six years. "It's an all-consuming position with the need for multiple abilities to deal with politics, science, education, finances and a constituency. It's not placid. You're never fully prepared for it."

But from physician to police detective to English teacher, Dr. Seward's friends describe the new EVP as a man who is part farm boy but cloaked in layers of scholarship, professionalism, and political savvy, and who is always the dedicated physician that he planned to be since the first grade at Francis Willard Elementary School in Rock Island, Illinois.

"It was probably our mother's long, chronic illness that influenced John to be a doctor. He knew from that time what he wanted to be," says Dr. Seward's sister and only sibling, Mrs. Ann Robinson, of Macomb, Illinois, an artist and retired English teacher. "We always hung together. Later, when our families were young, though we were living 100 miles apart, if a kid was sick or fell out of a tree, he was always there with sympathy and advice. He's always been a good listener."

Others echo that theme. "He is perceptive; he has a brightness and a quickness to size up situations and

individuals," says William R. Felts, MD, who chaired the AMA Council on Legislation during Dr. Seward's early days as a Council member, and who credits Dr. Seward with "an almost innate ability to identify phonies." Dr. Felts, now Professor Emeritus at George Washington University Medical School, also extols Dr. Seward's

dependability. "Count on him to do what he says. But above all he has a very, very high level of integrity. He's a really unique individual!"

"Doc Seward's a natural, born leader," says former Chief of Detectives, Gene Coots, of Winnebago County, Illinois, "He's always bringing people together, synergistically. He just knows how to do it and he's the best at it that I ever knew."

Detective Coots knows John Seward as few people do. They spent long, often tedious, sometimes harrowing, hours together as Dr. Seward fulfilled the role of Winnebago County Coroner. During the miserable times, it was Dr. Seward's companionship and sense of humor that brought the law officers through and "made the events memorable" for Coots. "Like

the evening I was at a retirement party when Doc called me away because a body had been discovered near the cemetery. It was miserable weather and the body was found along the river bank. John realized it was an American Indian, buried 150 years ago. We spent half the night digging there, and sent the remains to the Smithsonian. Doc knew I'd missed a steak dinner. He kept promising to buy me a steak for breakfast but the best he could do after midnight was a plate of ham and eggs. Or the Christmas Day we left our families to determine why x-rays of a murder victim showed a

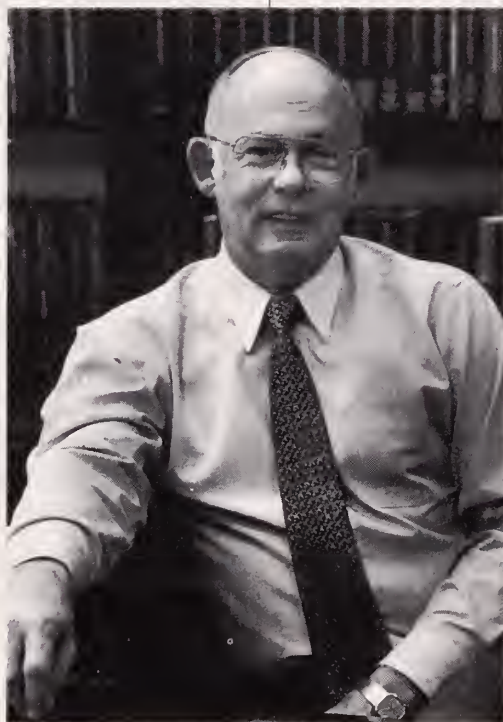


Photo by: Ted Grudzinski

number of pellets we hadn't expected to find there. Doc was so methodical, he went through old hospital records half the night, eating Big Macs and cold fries while our families had a more traditional meal. He finally discovered ... [a prior wounding] when the victim wouldn't let them take the pellets out. Doc will work 'til he drops and he knows how to demand things of others and make them want to succeed. And the good of his staff is always on his mind."

The good-natured give-and-take of the Coroner's office once found Dr. Seward remarkably on the receiving end. On his 50th birthday, wife Dusty, his sister Ann and friends planned a surprise party for him that has to stand as a bench mark for surprise events. "We rented a restaurant hall in an old neighborhood of Rockford," Ann Robinson recalls. City and Sheriff's police were in on it. "The Deputy Coroner called John and said there had been a multiple mob slaying there. All the guests were lying on the ground, their outlines chalked on the floor, when the Coroner burst in. He was shouting, 'Don't anybody touch anything!' when the lights came up and the "victims" began to move. John was delighted with the way that we had set him up."

Well, naturally. A love of dramatics is an important side of P. John Seward. Many who frequented Rock Island's Community Theater still remember Seward as Falstaff in Shakespeare's "Henry IV" — or as Lennie, in Steinbeck's "Of Mice and Men." Then there was the two-hour one man show he did at the Medical School theater in Rockford, Illinois, with portrayals of the great speeches of the English language. "He could pitch his voice to the high tones of Abraham Lincoln," remembers Gene Coots, "or give you

that Winston Churchill growl. But compliment him on an amazing performance and he won't go for any ego trips. He'll just say, "Oh, *you* could do that, just as well!"

The many parts of the man go together to make "the consummate politician," says retired family physician Charles Hair, MD, of Santa Paula, California, once Dr. Seward's Vice Chair on the Council on Legislation. "He's a farm boy whose expressed naivete is belied by his common sense, political savvy and silver tongue," says Dr. Hair. "Out of this farm boy come soliloquies that are beautiful to hear, but always he's the dedicated family practitioner. Patients always were — and always will be — his foremost priority."

Dr. Seward's friends agree that his unique combination of qualities and talents will continue to benefit the AMA. "He listens, he's receptive, keeps others in mind and can persuade without becoming confrontational," says Ann Robinson. "He'll continue to be the patients' advocate, while again proving himself a very effective manager," says Dr. Hair. "Colin Powell reminds me of Doc," Gene Coots believes. "He's concerned about the right things, about morality. He rises to leadership almost reluctantly but he's the epitome of leadership — nothing soft. He's loyal and unpretentious, and has quite an effect on people." "He's very capable and deserving," says Dr. Felts. "He'll make a great EVP!"

Former EVP Dr. Jim Todd agrees. "John's strengths are in building consensus. He understands the political process. He has management experience. I don't think he's grasped the magnitude of what he's gotten himself into — but he's got all the attributes necessary!" ♦

P. John Seward, MD

Born 1939, Illinois

1990-1996 AMA Board of Trustees

1994-1995 AMA Chair BOT

1972-1995 Winnebago County Coroner

1965 MD, University of Illinois College of Medicine

Residency – Family Practice – Mayo Clinic

Diplomate, Amer. Academy of Family Physicians

Dr. Seward and his wife, Dusty, have three children.

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The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

- Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
- Individual medical service
- Community health, education and civic betterment
- Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

AWARD NOMINATION FORM

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☐ Distinguished Service Award (Physician)

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Honors and Awards: _____

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision.)

Name of Person or Group Submitting Nomination: _____

Address: _____

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Please fill in and mail to: KMA, Attn: Awards Committee, 301 N Hurstbourne Pky, Ste 200, Louisville, KY 40222

Deadline for receiving nominations is July 15.

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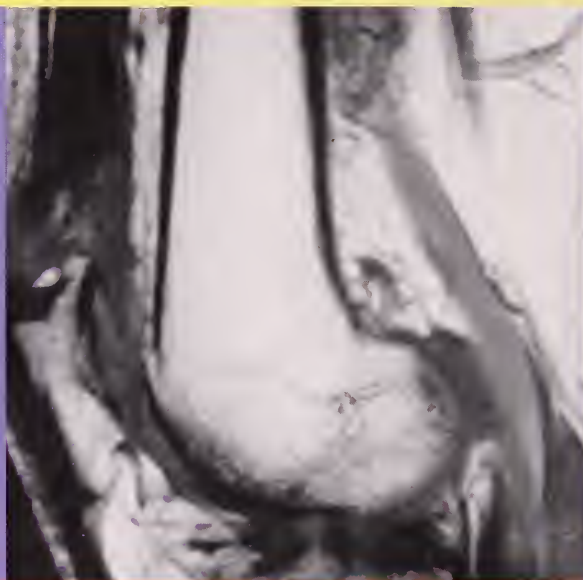


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VOLUME 94, NUMBER 7

JULY 1996

| | | |
|------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| COVER STORY | "Derby City" Hosts 1996 KMA Annual Meeting | 267 |
| SCIENTIFIC | Ten Year Experience With Infrainguinal Revascularization for Limb Salvage <i>Thomas W. Klamer, MD; Salem M. George, Jr, MD; Glenn E. Lambert, MD</i> | 270 |
| | Recognizing the Allergic Child <i>Erwin A. Jones, Jr, MD; Catherine C. McCormick, LPN</i> | 278 |
| SPECIAL ARTICLE | Carpal Tunnel Syndrome Effects of Litigation on Utilization of Health Care and Physician Workload <i>Morton L. Kasdan, MD, FACS; Michael I. Vender, MD; Kathleen Lewis, BA; Shawn P. Stallings, MD; J. Mark Melhorn, MD</i> | 287 |
| EDITORIAL | The Bright Side <i>Stephen Z. Smith, MD</i> | 291 |
| ASSOCIATION | <i>Monitoring Medicine</i> William P. VonderHaar, MD, Named Citizen Doctor of the Year Robert G. Cox, KMA's CEO, Honored With KHA Award of Excellence News | 263 295 296 297 |
| DEPARTMENTS | President's Page Advertisers' Guide Alliance Page Classifieds Continuing Education Information for Authors Letter to the Editor | 261 302 292 301 294 290 286 |



COVER: Join us in Louisville, Wednesday through Saturday, September 25-28, for the 1996 KMA Annual Meeting.

This issue contains a short, informative article on hotel and parking accommodations, as well as an overview of the highlights offered by the progressive city of Louisville. See page 266.

Design and artwork by Lee Wade of Louisville.

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The National Legislative Scene

The national legislative scene for medicine is unchanged from last year. Our priorities remain the same. Although we were successful in the House, the Senate did not pass several of our legislative objectives in their deliberations, including medical tort reform. What did get passed in the Medicare Preservation Act of 1996 was vetoed by the President. Now we are back to square one. We are still pushing for liability reform, relief from antitrust regulations, CLIA reform, relief from Stark I and Stark II, health insurance reform, and patient protection provisions.

It was the consensus of the Kentucky congressional delegation that we would not see a full Medicare Revision Act this year, but would see incremental revision bills put forth. The first and most popular one is the Kassebaum-Kennedy Bill, S 1028. It is primarily a health insurance reform bill. The Senate seems fairly set on keeping it that way. A similar bill, presented in the House by Congressman Archer from Texas, has passed and includes provisions for tort reform. Most recently, onerous provisions relating to fraud and abuse in the Medicare program have been proposed that call for criminal penalties for unknowing acts by physicians, the use of confidential software for identifying "abuses," and monetary penalties used as awards to government agencies which "discover" abuse. Needless to say, we are making all-out efforts to remove and change these issues. We have a lot of support in the House and hope that we can be successful in our effort.

Henry Hyde from Illinois has

introduced a separate bill, HR 2925, asking for antitrust relief for physician-sponsored networks. Most of our Kentucky delegation has signed on as cosponsors and understand how important this is if we are going to be able to compete in the marketplace.

Of course, by the time you read this, it may all be moot. Although I feel we will be successful in the House in our efforts, I don't think the Senate will include favorable provisions in the final bill. They want some kind of bill passed this year, and they think health insurance reform can be done. They do not want their simple bill cluttered up with amendments.

Any other action concerning Medicare or Medicaid will be delayed and will become a political football for the November election. There will be no block grants for Medicaid this year and maybe not for next year. I sensed a lot of opposition to block grants from Kentucky's delegation.

On the AMA level, the biggest agenda item is the Federation Study. This will take considerable time at our annual meeting in June, and it is my personal opinion that it will not be resolved when we leave. I don't think a consensus has been reached on this far-flung proposal.

As you all know by now, Bob Goodin was elected to the Council on Medical Education at our December meeting. The AMA Delegation would like to thank all of you who made this a successful campaign.

Donald C. Barton, MD
Senior Delegate, AMA

"Any other action concerning Medicare or Medicaid will be delayed and will become a political football for the November election. There will be no block grants for Medicaid this year and maybe not for next year. I sensed a lot of opposition to block grants from Kentucky's delegation."

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MONITORING MEDICINE

NEWS FOR KENTUCKY PHYSICIANS

Ad Hoc Committee to Develop a Comprehensive School Health Education Plan

In 1995, the KMA Child and School Health Committee reaffirmed the KMA House of Delegates position that health education should be taught to all students from kindergarten through the 12th grade. The committee recommended the development of a comprehensive school health education plan of which parenting and family life skills is a facet and that an ad hoc committee be formed from individuals in the private sector, government, and physicians to study school health education and to present recommendations to the KMA House of Delegates. The Board of Trustees appointed the Ad Hoc Committee in October 1995 and the Committee has been developing a strategy and plan to implement the goal established by the House of Delegates.

Community Level Action Sheet

The Charge:

The bottom line of comprehensive school health education (CSHE) begins at the local level. Our children and their families have unhealthy lifestyles. Education that is sequential, comprehensive, and integrated into preschool through high school is required if we plan to equip children with skills to be healthy, whole individuals. Physicians are key to successful implementation at this local level.

The Background:

It is clear that unhealthy lifestyles account for more than 50% of early mortality of our children. It is also intuitively obvious that single intervention cannot change these lifestyles. Issues of violence, low self-esteem, smoking, drug abuse, suicide, etc, need consistent, persistent educational efforts to alter these undesired outcomes. The American Cancer Society (ACS) conducted a Gallup Poll of school health education in 1994. The results showed very strong support for CSHE by parents, students, and school administrators. Over 80% of each group said that health education was of equal or more importance than other academic subjects. Who better to lead the efforts to promote health than physicians? By collaboration with parents and other community leaders, we can make a difference. The following actions should help you through the process to better health through comprehensive school health education.



Specific Actions:

- ☐ Identify and contact local school district health coordinator: find out what health education is occurring in schools, who makes health education decisions, and who in the school district is interested in health education (ie, school nurse, school administrator).
- ☐ Develop or join, if existing, a school health advisory board, under the auspices of the school district. Ask superintendent or school board to authorize this board. Suggested members, each who has an interest in health education include physicians, school nurses, dentists, psychologists, parents (ie, PTA), teachers (particularly health), child advocates, business leaders, etc.
- ☐ Encourage parents to find out what their child is being taught about health at school and enlist their support for CSHE. (PTA pamphlets called "Healthy Children, Successful Students" is an excellent resource to give out to parents.)
- ☐ Do a health needs assessment to define local health issues. Local data has more meaning to local communities. Assess smoking rates, drug use, teen pregnancy, suicide, violence, etc. Consider asking the school to administer the Youth Risk Behavior Survey, available through CDC.
- ☐ Enlist local media to inform them of child health concerns. Once they are informed, ask them to support the advisory council recommendation for CSHE.
- ☐ Consider being a school medical advisor to develop support within the school administration structure. This can be rewarding and very helpful toward reaching CSHE goals.
- ☐ Contact KMA Chairperson of the Child and School Health Committee. This person can put you in touch with other physicians in your state working at the local level. You can learn from their experience.
- ☐ American Cancer Society has published national standards for CSHE. These will be useful to you. A copy can be obtained from ACS. ACS also has completed a Gallup Poll of parents and administrators opinions on CSHE. It is very good and is available from local or state ACS offices.

Resources:

- ☐ American Academy of Pediatrics Legislative Packet on School Health Education (1-800-433-9016). Ask for Division of Government Affairs (AAP members can receive a free packet). **Excellent—A MUST** Contains ACS Gallup Poll and Health Education Standards.
- ☐ American Cancer Society, 1599 Clifton Road, Atlanta, GA 30329. A state CSHE coordinator and task force should be in place in each state. Kentucky ACS office is in Louisville (502-584-6782).
- ☐ Holly Conner, Kentucky Department of Education Resource Library (502-564-3791).
- ☐ National School Board Association, 1680 Duke Street, Alexandria, VA 22314. Several publications are available on CSHE (708-838-6722).
- ☐ CDC Division of Adolescent and School Health. Good resource and up-to-date information. They are developing CSHE guidelines. Copy of state specific Youth Risk Behavior Survey (404-488-5327).
- ☐ KMA Committee on Child and School Health.

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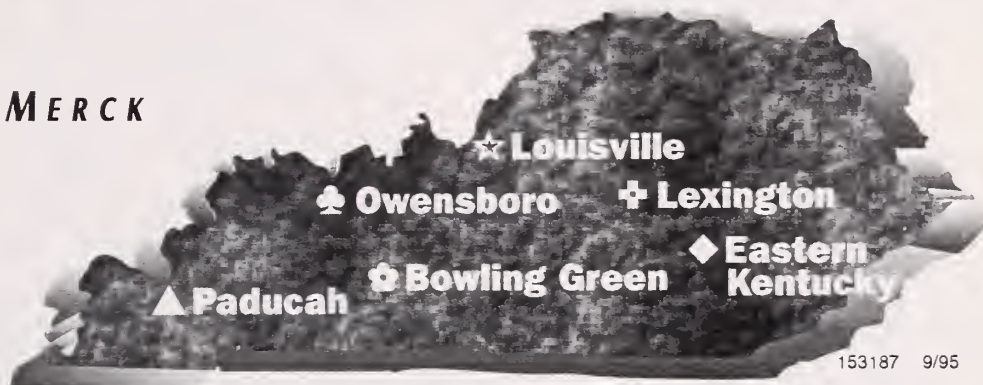


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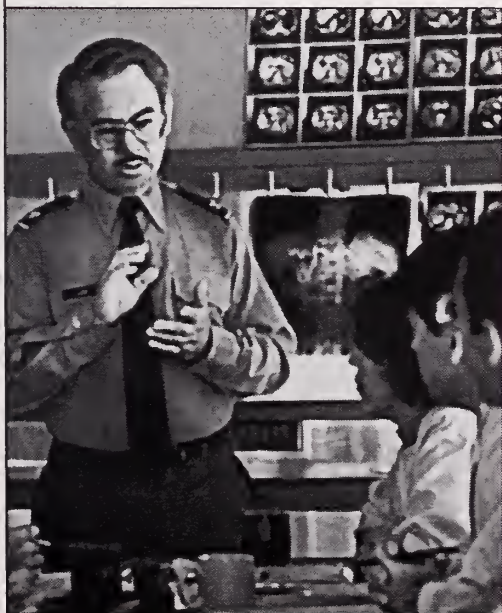
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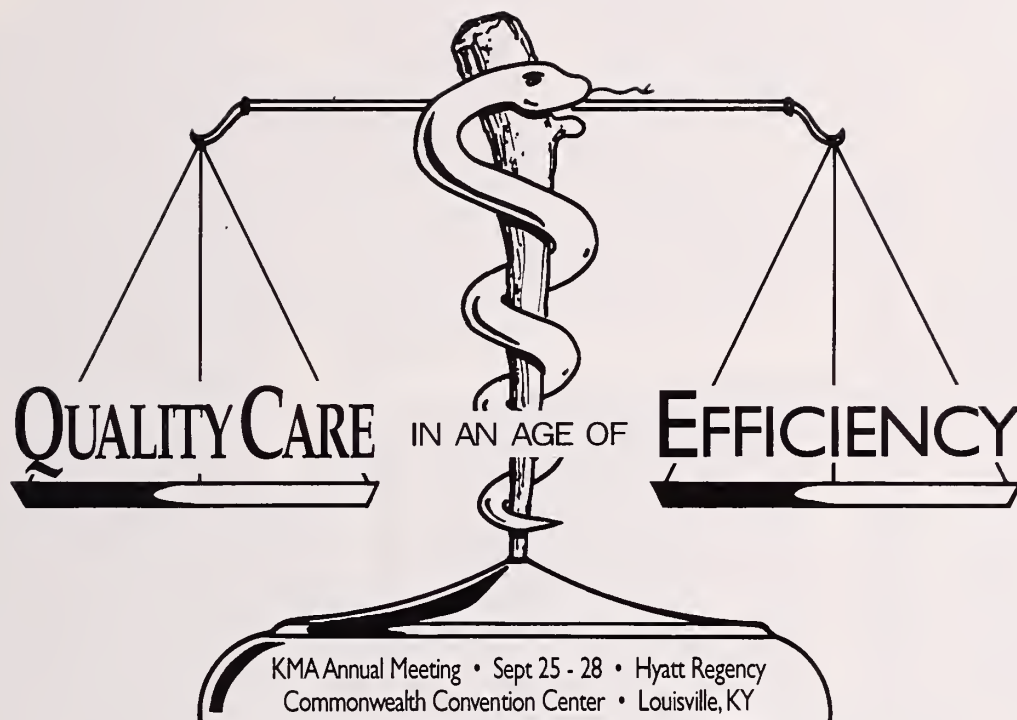
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revolving rooftop restaurant that offers a delicious lunch and dinner menu and a breathtaking view of the Louisville skyline. All business meetings and food functions will be held in the Hyatt.

It is important that you make your room reservations as soon as possible for this year's meeting by calling the Hyatt — 502/587-3434. **Please be sure and indicate that you are attending the KMA meeting** in order to receive **the special convention rate** of Single — \$76/Double — \$86.

The Commonwealth Convention

The Hyatt Regency and Commonwealth Convention Center are both ideally located to take advantage of sight-seeing, shopping, and dining, and downtown Louisville offers a wealth of things to see and do.

Center, located at 221 Fourth Avenue, will host KMA's General Sessions, specialty group meetings, and exhibit hall. The main registration desk will be located in the Convention Center. The Commonwealth Convention Center is one of the most functionally designed facilities of its kind with versatile lighting, computer climate control, and a sophisticated sound system. Complimentary coffee and danish, an exhibitor's lounge, and a snack bar will again be offered in the Exhibit Hall.

Shopping and Sightseeing

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Within a few blocks is the Louisville Science Center with exhibits of modern technology and ancient history along with the IMAX theatre that combines a huge image on a 4-story tall screen with a 27-speaker surround sound system. Close to the museum is the Kentucky Art and Craft Gallery featuring works by Kentucky artists. Other downtown attractions include the Kentucky Center for the Arts, Actors Theatre of Louisville, lunch or dinner cruises on the Ohio River aboard the Star of Louisville, the McCauley Theatre, Louisville Gardens, and the new Hillerich and Bradsby Museum.

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Ten Year Experience with Infrainguinal Revascularization for Limb Salvage

Thomas W. Klamer, MD; Salem M. George, Jr, MD; Glenn E. Lambert, Jr, MD

From the Department of Surgery, University of Louisville, Louisville, KY. Presented at the Eighteenth Annual Meeting of the Southern Association for Vascular Surgery, Scottsdale, AZ, Jan 26-29, 1994.

Reprint requests to Thomas W. Klamer, MD, 4B Suburban Medical Plaza, 4001 Dutchman's Lane, Louisville, KY 40207. Phone 502/897-0635 or FAX 502/895-3219.

Background: Revascularization is the only alternative to amputation for patients with severe, symptomatic infrainguinal ischemia. It is the purpose of this study to determine the success of revascularization as defined by limb salvage in a personal 10-year operative experience.

Methods: Primary infrainguinal bypass procedures were performed on 312 threatened limbs of 271 consecutive patients in the period between January 1, 1983, and December 31, 1992. Repeat revascularization was performed for failing/failed grafts as long as the extremity was viable and an outflow vessel could be found by either preoperative or intraoperative angiography.

Results: Ten patients died within 30 days of the primary procedure (4%) and the 5-year patient survival was 57%. Major amputations (AK or BK) were performed on 50 extremities over the 10-year period; cumulative 72-month limb salvage was 72%. Fifty-eight of the 312 extremities (19%) required 81 reoperations for failing/failed grafts, including a second procedure in 58, a third procedure in 14, and a fourth procedure in 9. Graft occlusions in which revision was either not attempted or was ultimately unsuccessful occurred in 72 extremities and led to 44 amputations. Cumulative primary and secondary graft patency for autologous conduit was clearly superior to nonautologous conduit (57% and 67% vs 20% and 21% respectively at 60 months).

Conclusions: We believe that this approach to infrainguinal revascularization is warranted as the mortality is low and the likelihood of success is high. A long term commitment to careful postoperative surveillance is mandatory as reintervention is frequently required to maintain graft patency and limb salvage.

by nonhealing ulceration, severe rest pain, or gangrene are two: primary amputation for symptomatic relief or revascularization for limb salvage. It has been our practice to attempt revascularization on almost all patients with threatened limbs and to repeat revascularization as long as the extremity is viable and an outflow vessel can be found either by perioperative angiography or by intraoperative exploration. Only those nonambulatory patients with knee/hip contractures, with extensive gangrene, or with acute life-threatening illness were considered noncandidates for revascularization. The safety and success of this approach are the subjects of this report.

Materials and Methods

From January 1, 1983, through December 31, 1992, the office and hospital records of 405 consecutive patients who required infrainguinal revascularization for chronic lower extremity ischemia were retrospectively reviewed. Claudication was the only symptom for 134 of the 405 patients with 157 symptomatic extremities. The ages of this group of patients ranged from 20 to 85 years (mean 68). The natural history of patients with claudication represents only a small threat for limb loss;^{1,2} therefore this group with claudication only was not considered further for the purposes of this study.

Conversely, patients with severe ischemia manifested by rest pain, nonhealing ulceration, or gangrene represent a high risk for limb loss and it is this group of patients that is the focus of this study. All patients with chronic severe ischemia were considered for revascularization except those who had forefoot and/or hindfoot gangrene so extensive that subsequent debridement would not render an adequate plantar surface, those who were bedridden with hip and/or knee contractures, and those who had acute life threatening illness (eg, acute stroke with coma, acute myocardial infarction with hemodynamic instability). Patients with acute limb threatening ischemia (ie, acute arterial embolus in 68 extremities, thrombosis in situ in 17 extremities, thrombosed

The operative treatment of the severely ischemic leg continues to challenge the surgeon in relation to patient selection, choice of procedure, and utility of repeated revascularization in the face of failing/failed grafts. The choices for the patient with an ischemic extremity affected

popliteal aneurysm in 4 extremities, and ruptured femoral pseudoaneurysm in 1 extremity) were also excluded from this study. Revascularization was performed on 271 patients with 312 severely ischemic extremities defined by ankle/brachial index less than 0.4 or toe pressure less than 30 mm Hg and/or manifested by rest pain in 177, gangrene in 72, and nonhealing ulceration in 93. The ages of the 271 patients in this group ranged from 30 to 93 years (mean 78). No patients were treated nonoperatively. Only those patients whose first infrainguinal revascularization was subsequent to January 1, 1983, were considered for the purposes of this study. All operations were performed at one of three community hospitals by one of the coauthors (TWK, SMG, GEL).

Risk factors in this group of patients included diabetes in 128 (47%), coronary artery disease in 135 (50%), history of smoking in 137 (48%), hypertension in 145 (54%), stroke in 5 (2%), and renal failure in 11 (4%). Preoperatively, patients were evaluated for cardiac disease by history and physical examination and EKG in the manner described by Taylor et al.³ Severe symptomatic coronary disease prompted cardiology consultation and further evaluation.

Technique. All patients underwent preoperative angiography utilizing both biplanar and digital imaging techniques combined with reactive hyperemia if necessary. The non-visualization of a recipient outflow vessel using these techniques did not preclude operative intervention. These patients underwent either selected distal tibial exploration determined by an audible Doppler signal or exploration of the inframalleolar vessels in the absence of a Doppler signal. The patency of the recipient outflow vessel was confirmed by

intraoperative angiography performed prior to bypass. Absence of a patent recipient vessel precluded bypass attempt.

For initial procedures the preferred proximal anastomotic site was the common femoral artery or limb of a previously placed aorta-femoral graft (287). However if conduit length was compromised, the inflow artery chosen was more distal at a site of demonstrable absence of proximal hemodynamically significant stenosis. Direct arterial pressure measurements proximal and distal to a stenosis of indeterminate hemodynamic significance were performed either percutaneously during the preoperative angiogram or by cut-down intraoperatively. A 15 or more mm Hg gradient was considered hemodynamically significant. This finding required correction either by percutaneous transluminal angioplasty or proximal bypass procedures. In this cohort the site of the proximal anastomosis was the profunda femoral (4), superficial femoral (6), above-knee popliteal (4), below-knee popliteal (5), and tibial-peroneal trunk (1).

The distal arterial anastomoses were constructed at the above-knee popliteal (24), below-knee popliteal (59), tibial-peroneal trunk (4), peroneal (60), anterior tibial (62), posterior tibial (56), dorsalis pedis (40), and inframalleolar posterior tibial or plantar branch (7) as seen in Table 1. The choice of the site for the distal anastomosis was based on the length and quality of autologous conduit and angiographically-demonstrated continuity of the outflow vessel with the pedal arch. Of note, the distal anastomosis was performed below the knee in 92%, of which 73% were to tibial vessels, including 15% to inframalleolar vessels.

Table 1. Sites of proximal and distal anastomoses for 312 lower extremity revascularizations

| | | Distal Anastomosis | | | | | | | | TOTAL (%) |
|----------------------|----------|--------------------|--------|-----|------|------|------|------|-----|-----------|
| | | AK Pop | BK Pop | TP | PT | AT | Per | DP | PB | |
| Proximal Anastomosis | ABF/CFA | 21 | 55 | 4 | 50 | 57 | 58 | 37 | 5 | 287 (92) |
| | SFA | 1 | 2 | — | 1 | 1 | 1 | — | — | 6 (2) |
| | PFA | 2 | 1 | — | 1 | — | — | — | — | 4 (1) |
| | AK Pop | — | — | — | 2 | 5 | 1 | 1 | — | 9 (3) |
| | BK Pop | — | — | — | 2 | — | — | 1 | 2 | 5 (2) |
| | TP Trunk | — | — | — | — | — | — | 1 | — | 1 (03) |
| | TOTAL | 24 | 58 | 4 | 56 | 63 | 60 | 40 | 7 | 312 (100) |
| | (%) | (8) | (19) | (1) | (18) | (20) | (19) | (13) | (2) | |

ABF/CFA, Limb of aorto bifemoral graft or common femoral artery; SFA, Superficial femoral artery; PFA, Profunda femoral artery; AK Pop, Above-knee popliteal artery; BK Pop, Below-knee popliteal artery; TP, Tibial-peroneal trunk; PT, Posterior tibial artery; AT, Anterior tibial artery; Per, Peroneal artery; DP, Dorsalis pedis artery; PB, Plantar branch of posterior tibial artery.

Infrainguinal Revascularization for Limb Salvage

Autologous greater saphenous vein in the in situ position was the conduit of choice (217). Preoperative duplex ultrasonographic vein mapping was performed in all patients since 1985. Exposure, anticoagulation, and anastomoses were performed utilizing standard techniques.⁴ All grafts were assessed intraoperatively with continuous wave Doppler ultrasound, completion angiography, and most recently with pulsed-wave Doppler with spectral analysis.

Reversed autologous saphenous vein grafts were utilized in 41 extremities for the initial procedure. Composite greater/lesser saphenous, lesser/lesser saphenous, greater saphenous/cephalic, lesser saphenous/cephalic, and cephalic/cephalic vein grafts were used in 12 extremities and non-reversed transposed greater saphenous vein grafts were used in 6 extremities. Reversed autologous veins were used as surgeon preference only when short length conduit was needed or anatomic considerations precluded the in situ technique. Composite grafts were used only if continuous greater saphenous vein was either missing because of previous harvesting or unsuitable because of thrombosis or sclerosis.

Nonautologous conduit was used in the initial or subsequent procedures only as a last resort if no autologous vein was available after a thorough search with duplex ultrasonography of both upper and lower extremities. It was generally preferred not to utilize the greater saphenous vein from the contralateral extremity particularly if there was significant occlusive disease on the basis of physical examination and/or ankle/brachial indices. Contralateral greater saphenous vein was used in preference to synthetic conduit but lesser saphenous and/or arm veins were used in preference to contralateral greater saphenous vein if the contralateral extremity was symptomatic and severely ischemic. Polytetrafluoroethylene (PTFE) was utilized initially either alone in 28 extremities or as a composite graft with autologous vein in 9 extremities and human umbilical vein was used in only one extremity, for a total of 38 initial nonautologous conduits.

Follow-up and statistics. Postoperatively all patients were followed with serial examination and ankle/brachial indices. Subsequent to 1985 a strict surveillance protocol was instituted which included ankle/brachial indices and duplex ultrasonography performed every 3 months the first postoperative year, every 6 months the second year, and yearly thereafter unless intervention was required. Duplex ultrasonographic graft sur-

veillance as described by Bandyk et al⁵ was routinely performed at these scheduled checkups. A decrease of 0.15 in the ankle/brachial index, evidence of severe spectral aberration or focal stenosis on duplex scan, or graft flow velocities consistently less than 40 cm/sec necessitated angiography. Graft revision for *failing* grafts was performed if an anatomic defect (ie, retained valve, thrombus, or stenosis of greater than 50% of the diameter of the graft or the anastomosis) could be found regardless of symptoms. Extremities with *failed* grafts were not reoperated if the patient was asymptomatic. If reintervention was necessary, postoperative surveillance resumed as for a new graft (ie, every 3 months the first year, every 6 the second year, and yearly thereafter). Patients were routinely seen by one of the authors at regular intervals correlated with scanning surveillance unless any postoperative complications necessitated more immediate attention. Concerns about graft patency or limb status expressed at any time by either the patient or the family prompted immediate physician interaction and examination. End points for follow-up were death of the patient, major amputation, or graft occlusion without successful revision.

Reoperation was considered for every patient whose graft was failing/failed. The decision to *not* reoperate was made if the initial presenting ischemic lesion resolved (ie, healed ulceration or toe amputation site) in the interim since the original graft and the extremity was asymptomatic. Reoperation was also not undertaken if the operating surgeon believed that graft patency could not be sustained based on the poor quality of the outflow vessel. This decision took into consideration the various conduits used and the postoperative use of anticoagulation.

All results of graft patency and limb salvage were calculated by the life table method and standard errors were estimated according to the criteria suggested by the ad hoc committee on reporting standards of the national vascular societies.⁶

Results

Morbidity and mortality. Ten patients (4%) died within 30 days of the initial procedure. Nine of these deaths resulted from acute myocardial infarction and one from pneumonia following acute stroke. The ages of the nine patients who succumbed to acute myocardial infarction ranged from 29-82 years (mean 71 years). Six pa-

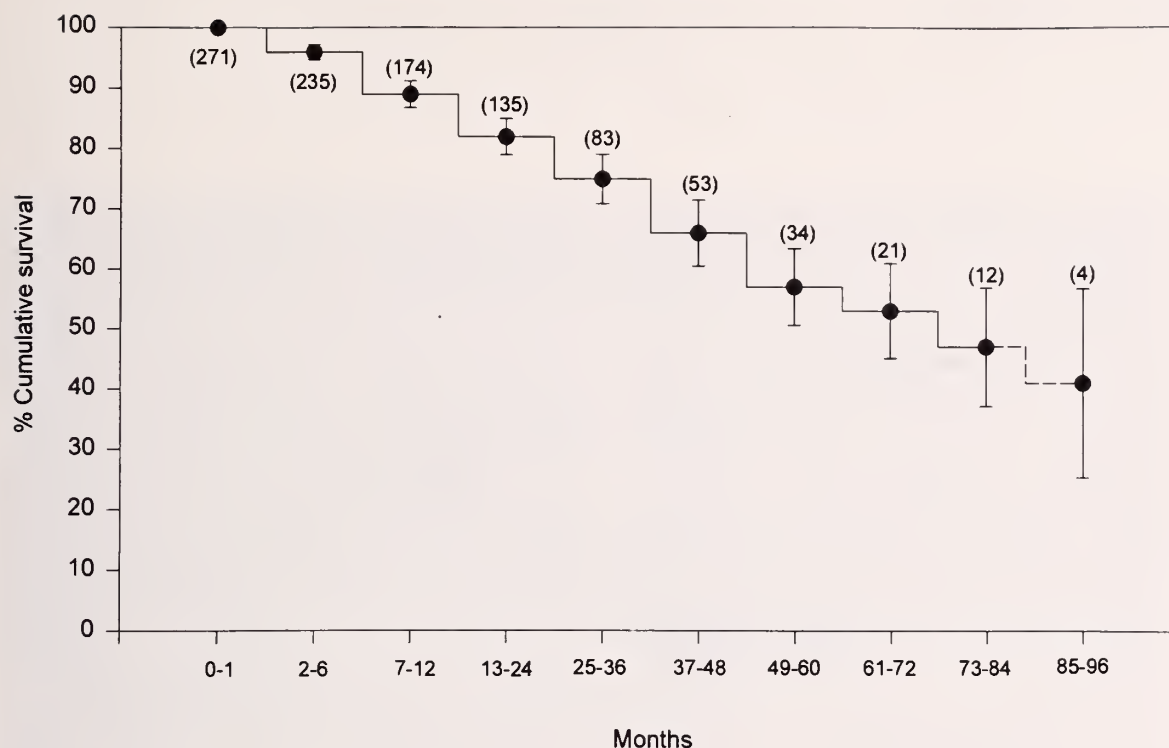


Fig 1 — Life table of cumulative survival for 271 consecutive patients operated for limb salvage.

tients had had previous myocardial infarctions however only one of these patients had symptomatic coronary disease at the time of surgery. One of these patients had preoperative coronary bypass grafting for unstable angina 6 months prior to his leg revascularization and was asymptomatic at the time of surgery. There were no deaths within 30 days of any reoperative procedure. Cumulative patient survival at 1, 5, and 7 years was 89%, 57%, and 47% respectively as is seen in Fig 1.

Major complications which were not graft related occurred in 5 patients: 2 with nonfatal acute myocardial infarction, one with acute diverticular bleeding, one with acute deep venous thrombosis in the contralateral leg, and one with acute encephalopathy. Major non-thrombotic graft related complications requiring reoperation occurred in 17 (5%) extremities: hemorrhage in 9 (3%); infection in 6 (2%), and hematoma in 2 (1%). Seroma with superficial wound separation and fat necrosis was seen infrequently in the experience.

Reoperation. All patients in whom reoperation was considered underwent either pre- or intraoperative angiography. There were 108 grafts that were failing or failed. One of these patients was lost to follow-up. Forty-nine of these extremities were not reoperated either because the initial foot lesion resolved, which occurred in 27 extremities, or because the operating surgeon believed that graft patency could not be sustained based

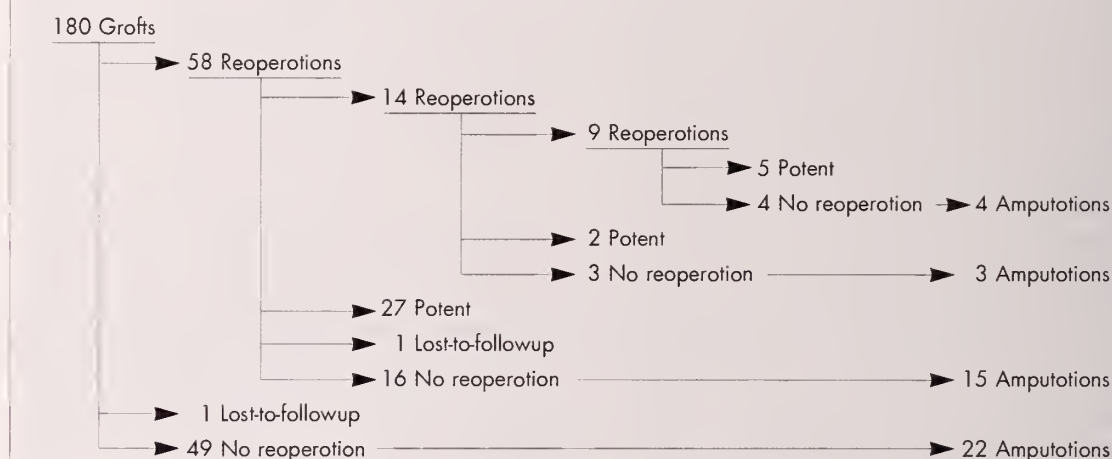
on the poor quality of the recipient outflow vessel, which occurred in 22 extremities all of which were amputated. The remaining 58 of the 107 extremities whose grafts were failing/failed underwent a total of 81 revascularization procedures including a second procedure in 58 extremities, a third procedure in 14 extremities, and a fourth procedure in 9 extremities. One of the 58 was lost to follow-up. Patency was ultimately achieved in 34 and amputation was avoided. Patency could not be sustained in 23 extremities and amputation was necessary in 22, as seen in Table 2. A total of 72 grafts occluded in which reoperation was not undertaken and led to a total of 44 subsequent amputations.

Further stratification of graft failure, reoperation, and amputation was specified according to the time from the initial revascularization procedure. Nineteen grafts thrombosed or were failing immediately (within 24 hours from the initial procedure). Four of these 19 were not reoperated, and 3 of these 4 extremities were amputated. Fifteen of the 19 were reoperated. Patency was established in 6 of these 15, but 9 failed again. Three of these 9 extremities were not reoperated, and all 3 were amputated. Six of these 9 were reoperated a third time and all failed. Five of the 6 were reoperated a fourth time. The single extremity not reoperated was subsequently amputated. Patency was achieved in 2 of the 5 that were reoperated, but 3 failed a fifth time and all 3 were amputated.

Infrainguinal Revascularization for Limb Salvage

Table 2.

Failure / Reoperation / Amputation



Of the total 19 extremities whose grafts failed immediately, amputation was eventually required in 10 of the 11 in which reoperation was either not attempted or was unsuccessful (91%).

Twenty-one grafts failed in the early (greater than 24 hours and less than 30 days) postoperative period following the initial procedure. One of the 21 grafts was lost to follow-up. Eleven of the 21 were not reoperated which subsequently led to 7 amputations. Nine of the 21 grafts were reoperated, and one of these was lost to follow-up. Patency was achieved in 3 of the remaining 8 grafts for a mean of 16 months until the termination of the study (2) or eventual death of the patient (1). Five of these 8 grafts failed again after a mean of 4 months and led to 4 amputations. Of the 21 extremities whose grafts failed early, amputation was eventually required in 11 of 16 in which reoperation was either not attempted or was unsuccessful (69%).

Sixty-eight grafts failed late (greater than 30 days after the initial procedure; mean 12 months and range 31 days–61 months). Thirty-four of these extremities were not reoperated which led to 12 amputations. The remaining 34 underwent a second procedure in which patency was reestablished in 18. Sixteen of the 34 failed again, and 8 of these extremities were not reoperated at this point and all 8 were amputated. The remaining 8 were operated on a third time and patency was reestablished in 2, but 6 failed again. Two of these 6 extremities were not reoperated and both were

amputated. A fourth operation was performed in the remaining 4 extremities and patency achieved in 3. One graft failed again, reoperation was not attempted and the extremity was amputated. Of the total 68 grafts that failed late, 23 of the 45 extremities in which reoperation was either not attempted or was unsuccessful were eventually amputated (51%).

Reoperative procedures included the following: ligation of residual arteriovenous fistula following in situ procedure in 4; thrombectomy with or without vein patch angioplasty in 18; vein patch angioplasty alone in 13; Dacron patch angioplasty alone in 1; valve site resection with primary anastomosis in 2; jump graft from the existing graft to a more distal recipient outflow vessel with autologous conduit in 15; creation of a new graft with autologous conduit in 16; and creation of a new graft with nonautologous conduit in 12 extremities. Although it was preferred to use a new bypass graft from a virginal inflow vessel to a virginal outflow vessel utilizing autologous conduit, adequate length was occasionally a problem, therefore jump grafts with autologous vein from existing grafts was preferred to a new graft whose length required nonautologous conduit.

Graft patency (primary and secondary). The primary and secondary patency results were divided between autologous conduit (290 — including 274 original autologous and 16 replacement autologous grafts) and nonautologous

conduit (50 — including 38 original non-autologous and 12 replacement nonautologous grafts.) PTFE alone (28 initial and 12 subsequent procedures), composite PTFE with autologous vein (9 extremities) and human umbilical vein (1 extremity) were all considered as nonautologous conduit. When adequate autologous conduit was not available, 50 nonautologous conduits were utilized. Primary patency for autologous conduit was 68% and 57% and secondary patency was 77% and 67% at 24 and 60 months respectively, as seen in Fig 2. Primary patency for nonautologous conduit at 24 months was 36% and secondary patency for nonautologous conduit at 24 months was 39%, as seen in Fig 2.

Major amputation (above-knee or below-knee). A total of 50 major amputations (16%) were performed over the course of the study. Six of these (12%) were performed on extremities with patent grafts (5 for progressive gangrene and 1 for graft sepsis). The remaining 44 amputations occurred in extremities with occluded grafts. Twenty-nine amputations occurred in extremities

whose only or latest revised graft was autologous conduit, and 15 amputations were in extremities whose only or latest graft was nonautologous. Ten amputations were performed on extremities whose grafts first occluded immediately (within 24 hours from the initial procedure), and 11 amputations were performed on extremities whose grafts failed early (after 24 hours but within 30 days from the initial procedure). Twenty-three amputations were performed on extremities whose grafts occluded late (greater than 30 days from the initial procedure), including 5 extremities that were amputated greater than 1 year following the initial procedure. Cumulative 12- and 72-month limb salvage was 86% and 72% respectively by life table analysis, as seen in Fig 3.

Discussion

The immediate goal for the patient with a severely ischemic lower extremity is relief of symptoms and ultimately preservation of a useful extremity. Attainment of this goal requires unwavering attention to detail in terms of meticulous operative

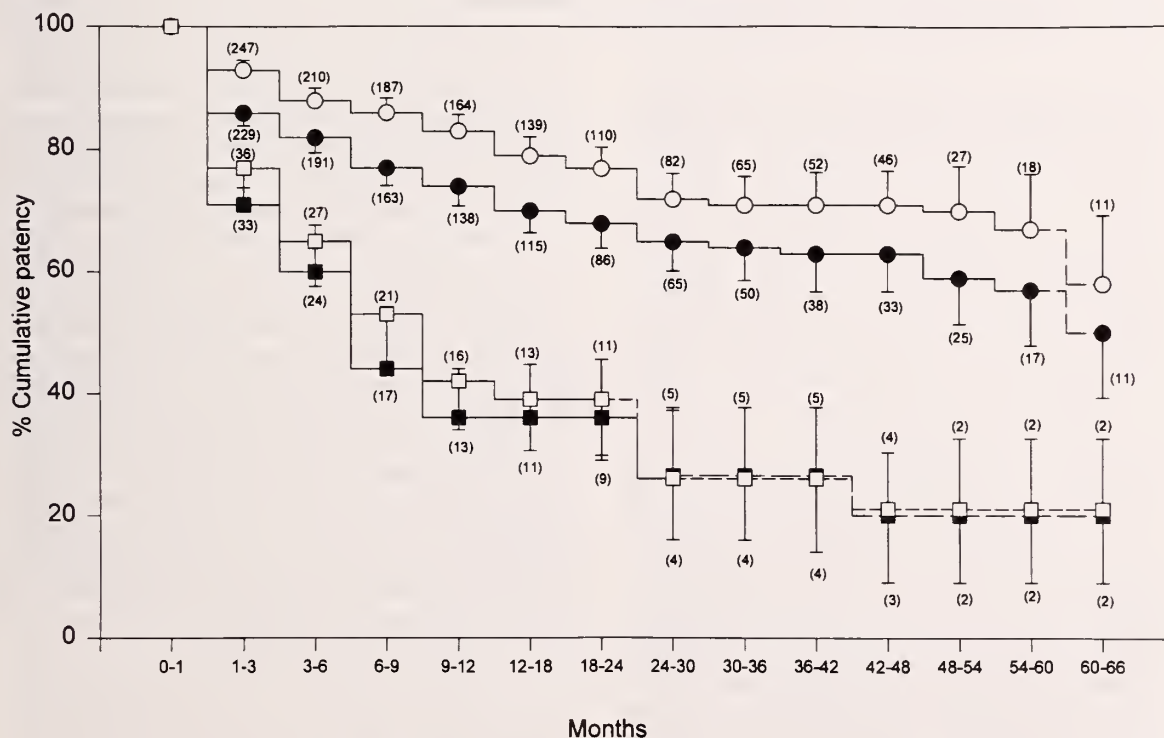


Fig 2 — Life table of cumulative patency for autologous conduit primary patency (closed circle), autologous conduit secondary patency (open circle), nonautologous conduit primary patency (closed square), and nonautologous conduit secondary patency (open square).

Infrainguinal Revascularization for Limb Salvage

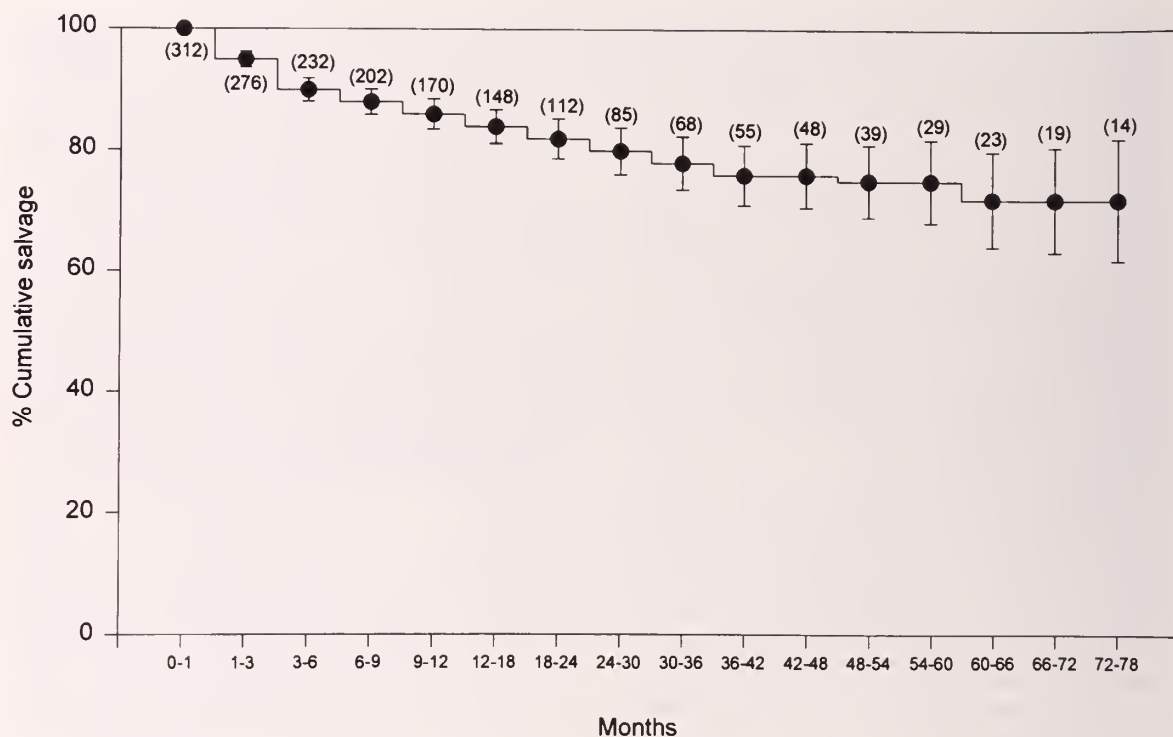


Fig 3 — Life table of cumulative limb salvage for 312 consecutive limbs.

technique and careful follow-up with low threshold for reoperation. Duplex surveillance, physical examination at frequent intervals, and liberal angiography is mandatory to identify those grafts at high risk for occlusion. Reoperation with graft revision or replacement is frequently necessary to maintain distal arterial flow and obviate amputation. Justification of this approach is predicated upon the premise that the procedures must be able to be performed safely with low morbidity and mortality, and successfully with acceptably low rates of major amputation.

A common mistake among inexperienced surgeons in the preoperative assessment of the patient with a threatened limb is misinterpretation of "inadequate" angiograms. Nonvisualization of a potentially patent recipient vessel in the distal limb should not necessitate amputation. Unless blood flow is angiographically identified in the foot preoperatively, cut down on either the dorsalis pedis or the inframalleolar posterior tibial artery with intraoperative angiography via a small gauge angiocatheter is performed to determine patency of the distal recipient vessel and whether or not the outflow is sufficient to sustain a graft to that level. Newer digital imaging techniques

have reduced the need for intraoperative cut-down. Continuous flow from the outflow vessel to the toes is desired, but isolated tibial segments have been associated with graft patency and more importantly limb salvage.⁷ For nonhealing ulceration or gangrene, graft patency is required for only a long enough period to allow healing; later graft failure does not necessarily lead to amputation as long as the presenting ischemic symptom has resolved and the extremity remains free from traumatic injury. Patient education regarding foot care is therefore of extreme importance.

The symptoms associated with lower extremity ischemia present a wide spectrum of atherosclerotic occlusive disease ranging from mild claudication to rest pain, nonhealing ulceration, and gangrene. It is important to distinguish between these two groups as the consequences of graft failure, particularly early, are quite different. Most patients with claudication whose grafts thrombose are restored only to their previous level of claudication.⁸ In contrast, those patients with advanced ischemia whose grafts thrombose and are not successfully revised have a high likelihood of limb loss.

A total of 81 reoperative procedures were

performed for 108 failing/failed grafts in 58 extremities, and 5-year limb salvage was achieved in 75%. In those extremities in which the graft failed and amputation was required, the etiology of the graft failure was felt to be multifactorial. Stenotic outflow arteries, increased outflow resistance, poor quality venous conduit, and marginal patient selection all contributed to graft failure both in the immediate and early postoperative periods.

In this series the amputation rate associated with ultimate graft failure was 91%, 69%, and 51%, for the immediate, early, and late intervals respectively. The high rate of amputation in the immediate period speaks to true critical ischemia; if the graft fails and patency is not reestablished the chances are high that amputation will be necessary. The somewhat lower rates of amputation associated with failed grafts in the early and late periods suggest that if healing can be achieved and the graft subsequently occludes, amputation may not be necessary as long as extremity remains free of ulceration.

In review of other recent series of vein bypasses, the primary and secondary patencies achieved here approach or are comparable to those results.⁹⁻¹¹ In addition, three fourths of all bypasses in this series were to infrapopliteal or inframalleolar vessels. It is for this reason that the in situ technique was most frequently used as the initial procedure. The ability to use smaller diameter veins for these smaller diameter recipient arteries, its reported durability to tibial arteries and accessibility of the graft for surveillance and revision were the determinant factors for this choice.^{10, 12, 13}

These data indicate that revascularization for severely ischemic lower extremities is safe and effective. Operative mortality was low for initial procedures and zero for reoperative procedures. Success, in terms of limb salvage, was achieved in 72% at 6 years. Meticulous intraoperative technique, fastidious postoperative vigilance, and commitment to reoperation for failing/failed grafts are mandatory requirements to maximize the potential for limb salvage in patients who otherwise would be doomed to amputation.

References

1. Cronenwett JL, Warner KG, Zelenock GB, et al. Intermittent claudication: current results of nonoperative management. *Arch Surg*. 1984;119:430-436.

2. Imparato AM, Kim GE, Davidson T, Crowley JG. Intermittent claudication: its natural course. *Surgery*. 1975;78:795-799.

3. Taylor LM, Yeager RA, Moneta GL, et al. The incidence of perioperative myocardial infarction in general vascular surgery. *J Vasc Surg*. 1992;15:52-61.

4. Levine AW, Bandyk DF, Bonier PH, Towne JB. Lessons learned in adopting the in situ saphenous vein bypass. *J Vasc Surg*. 1985;2:145-153.

5. Bandyk DF, Cato RF, Towne JB. A low flow velocity predicts failure of femoropopliteal and femorotibial bypass grafts. *Surgery*. 1985;98:799-809.

6. Ad Hoc Committee on Reporting Standards, Society for Vascular Surgery/North American Chapter, International Society for Cardiovascular Surgery. Standards for reports dealing with lower extremity ischemia. *J Vasc Surg*. 1986;4:80-94.

7. Veith FJ, Ascer E, Gupta SK, et al. Tibiotibial vein bypass grafts: a new operation for limb salvage. *J Vasc Surg*. 1985;2:552-557.

8. Naji A, Barker CF, Berkowitz HD, et al. Femoropopliteal vein grafts for claudication analysis of 100 cases. *Ann Surg*. 1978;186:79-82.

9. Veith FJ, Gupta SK, Ascer E, et al. Improved strategies for secondary operations on infrainguinal arteries. *Ann Vasc Surg*. 1990;3:85-93.

10. Leather RP, Shah DM, Chang BB, Kaufman JL. Resurrection of the in situ saphenous vein bypass: 1000 cases later. *Ann Surg*. 1988;208:435-442.

11. Taylor LM, Edwards JM, Porter JM. Present status of reversed vein bypass grafting: five year results of a modern series. *J Vasc Surg*. 1990;11:193-206.

12. Bergamini TM, Towne JB, Bandyk DF, et al. Experience with in situ saphenous vein bypasses during 1981 to 1989: determinant factors of long-term patency. *J Vasc Surg*. 1991;13:137-149.

13. Klammer TW, Lambert GE, Richardson JD, et al. Utility of inframalleolar arterial bypass grafting. *J Vasc Surg*. 1990;11:164-170.

Recognizing the Allergic Child

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This effort is dedicated to the late Dr Amos Christie, whose influence on us was great and who encouraged us by example to be accurate in diagnosis and specific in treatment.

The delivery of health care is currently in a state of transition with managed care emerging as a frequently used method for health care delivery. A major tenet of many managed care systems is that specialized care is costly and thus is to be delayed or avoided when possible. The end result of this philosophy is that primary care physicians will find themselves providing patient care which, in the past, had been provided by the specialist. In the field of allergy, as in any other specialty, providing adequate and appropriate care to the patient is incumbent on recognizing that the patient's symptoms are allergic in etiology. This is especially true when presenting symptoms are different from the classical signs and symptoms of allergy. This paper presents: (1) specific comments and suggestions which will enable the primary care physician to recognize the allergic child, (2) data from over 800 children referred for allergy evaluation to support the foregoing comments and suggestions and, (3) recommendations as to how primary care physicians might effectively manage most children with certain types of allergic disease without referral to an allergist.

Allergic diseases have the most significant impact of all the chronic illnesses that occur in the pediatric age group. Illnesses caused by or related to allergy are a primary cause for children's visits to physicians and days missed from school. Allergy related illnesses are also responsible for increased family or government medical expenditures and psychosocial conflicts in the home. In his book, *The Complete Allergy Guide*, Dr Howard Rapaport commented, "it is estimated that at least one-half of the entire world's population suffers from some type of allergy, mild or serious. One-third of all chronic diseases in children under age 17 are caused by asthma, hay fever or other allergic disorders. This makes allergy the most common cause of disability among school children."¹

At the present time, physicians find themselves in the midst of significant change in the

manner in which health care is provided. Insofar as allergy is concerned, it has been repeatedly shown that clinical outcomes from the treatment of allergy are significantly better in allergist-managed patients than in those followed by generalists. Nonetheless, it is felt by administrators of managed care systems that specialized care is costly and thus many managed care programs limit patient access to specialists.² As a result, in the future more responsibility for care of the allergic child is likely to fall on the shoulders of the primary care physician.

So it becomes extremely important that we, as physicians who treat children, recognize symptoms which are allergic in etiology or are allergy related so that a reasonable and proper course of treatment can be initiated.

This report is presented in three sections. First, specific comments and suggestions to enable primary care physicians (pediatricians and physicians in family practice) to recognize the allergic child; second, data from over 800 allergic children which support the comments and recommendations suggested in the first section of the paper; and third, suggestions as to how primary care physicians might effectively manage most children with certain types of allergic disease without referral to an allergist.

Part I

Many children are repeatedly ill with symptoms not recognized as allergic in etiology. At times, 2 or 3 years or longer may pass before something more than casual care is offered for treatment. Frequently, a child is seen repeatedly for the same combination of symptoms without the realization that there is some more basic underlying problem playing a role in those symptoms which recur so frequently. It is not unusual for children to come for an allergy evaluation, not on the recommendation of their physician, but rather on the advice of a friend or relative whose child exhibited the same symptoms in the past and is now symptom-free or much improved after an allergy evaluation and treatment directed toward the basic problem

which is allergy — allergy to indoor airborne allergens, molds, sometimes to foods, and much less frequently, to pollens.

This sequence of events occurs frequently because many primary care physicians have not been adequately taught to recognize the allergic child who demonstrates a constellation of symptoms or a pattern of illness different from classical pollen rhinitis or asthma. They do not appreciate that the child who is "sick all the time," "keeps a cold all winter," or seems to "pick up one illness after another," is probably an allergic child who requires more in the way of management than repeated rounds of antibiotics and decongestants.

The signs and symptoms of allergy may differ somewhat according to the age of the child. The same allergen may cause one constellation of symptoms during infancy and early childhood and, in the same patient, may produce an entirely different picture in later childhood and adolescence. Food allergens are a particularly good example of this phenomenon. It may also be that the sensitivity of the target organ varies with age so that certain signs and symptoms are more likely to occur at one age than another.

Abnormalities of growth and development may also have an allergic basis. The development of structures which undergo change as a child grows may be adversely affected by allergic disease. An example of this is orofacial dental deformities, usually malocclusion, which occur secondary to chronically engorged mucous membranes of the nasal cavities.^{3,4,5}

Taking a careful history is most important. The more complete the history, the more help it affords in recognizing the allergic child. This is particularly true in younger children and infants where subtle points in the history frequently provide the clue to a diagnosis of allergic disease. For example, constipation is not generally thought to be a symptom of a food allergy but, in fact, is a common complaint associated with milk intolerance; the infant who is "never satisfied" after a feeding of appropriate quantities is frequently not tolerating that formula; the history of onset of symptoms shortly after receiving a stuffed toy or moving to a different geographic location or a different home in the same area may provide subtle clues as to possible causes for the allergic symptoms.

The importance of a family history of allergy should not be overlooked. Many investigators have emphasized that parents with allergies are

Table 1. Helpful Criteria in Recognizing the Allergic Child from Birth to Six Months of Age

| | |
|----------------------|------------------------------------------------------------------------------------------------------------------------------------------|
| History | Excessive Spitting, Vomiting, "Colic" Constipation Diarrhea Runny Nose Nasal Stuffiness Skin Rash Cough Wheezing |
| Physical Examination | Abnormal tympanic membranes Fluid in the middle ear space Enlarged, pale nasal turbinates Nasal discharge Eczema Wheezing |
| Laboratory Studies | CBC Quantitative immunoglobulins (QIG's) Sweat Electrolytes Cultures |
| X-ray Studies | Congenital abnormalities |

more likely to have allergic children than parents with no history of allergic disease.

The following comments referable to recognizing the allergic child will relate to children in four age groups — birth to 6 months; 6 months to 2 years; 2 years to 6 years; and 6 years to adolescence. There is some overlap in signs, symptoms, physical findings, and laboratory tests because the same finding may be applicable to children in different age groups.

Birth to Six Months

Infants from birth to 6 months of age present most frequently with allergy symptoms referable to the gastrointestinal system (Table 1). Their symptoms are usually described as feeding difficulties and/or abnormalities in the pattern of stools. Symptoms of excessive irritability, frequently coupled with prolonged periods of intense crying during which times the legs are drawn up and flexed on the abdomen, are described by the term "colic." This group of symptoms occurs almost exclusively in artificially or non-breast fed infants. These symptoms are nearly always secondary to intolerance or sensitivity to a food, usually cow's milk. Excessive spitting or frank vomiting may signal an acute, nonallergic illness such as infection, intestinal obstruction, or a metabolic disorder. But these same symptoms occur in the infant with cow's milk or solid food sensitivity. When careful physical examination and appropriate laboratory and x-ray studies fail to reveal another

Recognizing the Allergic Child

etiology, milk or food intolerance should be considered likely. When the stool pattern is abnormal, either constipation or diarrhea may be present, but constipation tends to occur more frequently. Certainly, in my experience, milk intolerance is associated with constipation more than with diarrhea.

Skin rashes occur frequently in infants. Most are nonspecific or self-limiting and require no treatment. Others respond to supportive care. Some rashes are indicative of more serious illness, ie, systemic infection or malignancies. However, eczema in infants and children is frequently food related⁶ and, when present, appropriate steps should be taken to discover the offending food while general supportive measures are carried out.⁷

Nasal symptoms are almost as frequent as gastrointestinal symptoms in the allergic infant. This is probably the case because food allergens may cause nasal symptoms, as well as gastrointestinal symptoms, and it is not unusual to see enlarged inferior nasal turbinates, with or without nasal discharge, in the absence of gastrointestinal symptoms in infants with food sensitivity.

The physical examination of the infant whose allergic illness is not complicated by otitis, bronchitis, or pneumonia is usually less helpful than the history. Frequently, the physical examination is normal in every respect. However, recurrent acute otitis media and chronic serous otitis may occur in conjunction with allergic upper respiratory disease. Thus, it is always important to ascertain the status of the tympanic membranes.

Infants under 6 months of age with allergic upper respiratory symptoms usually have no significant findings in the lungs on physical examination. Frank asthma, if defined as reversible bronchospasm, is uncommon at this age. Wheezing may occur with pneumonia, bronchitis, congenital stridor or other congenital malformations, and foreign bodies or tumors — all of which must be differentiated from allergic disease. Wheezing may also occur in bronchiolitis which is characterized by the finding of rales and rhonchi, as well as wheezing. Wheezing secondary to allergic disease will nearly always clear after administration of a beta 2 agonist via nebulization.

Laboratory studies will occasionally help to distinguish the allergic infant. A complete blood count should be done to check for other nonallergic illnesses, but it usually contributes little to the diagnosis of allergy (in this age group). One exception to this statement is the finding of a

lowered hemoglobin and hematocrit in infants with cow's milk intolerance. This occurs secondary to microscopic but chronic blood loss through the gastrointestinal tract^{8,9} as long as the infant is receiving cow's milk. Quantitative immunoglobulins should also be determined so as not to miss the child with hypogammaglobulinemia or with a specific immunoglobulin abnormality. Infants' serum immunoglobulin levels vary with age and this should be kept in mind when interpreting test results. Any infant with recurring illnesses involving the lung should have a sweat electrolyte determination to rule out cystic fibrosis. Examination of the nasal mucus for eosinophils is not helpful in this age group.¹⁰ Nasopharyngeal culture of the infant with chronic rhinorrhea may reveal the presence of group A, beta hemolytic *Streptococcus*, or other pathogens. Streptococcal rhinitis or tonsillopharyngitis in this age group may be indistinguishable from inflammation due to other causes and appropriate cultures are frequently helpful.

A chest radiograph, with or without barium esophagram, is indicated in infants with recurring pulmonary disease. This should be done to rule out congenital malformation such as achalasia, TE fistula (H-type), congenital lobar emphysema, and so forth.

Six Months to Two Years

In this age group (Table 2) there appears the problem of recurring upper respiratory illnesses. These may be seasonal or perennial, depending on the offending antigen. An almost constant finding with allergic upper respiratory illnesses is the presence of *interval symptoms*, that is, *symptoms occurring during intervals between episodes of more acute illness*. This is one of the most helpful findings in determining whether a child's underlying problem is one of allergy.

Recurring acute otitis media or chronic OME frequently accompany allergic upper respiratory illnesses. Cough, frequently more prominent at night, and croup are also commonly associated with allergic upper respiratory disease.

Gastrointestinal symptoms continue to be important in this age group. These symptoms may occur as more solid foods are introduced into the diet. Diarrhea is less commonly found in younger children, but constipation continues to be a frequent complaint.

Skin problems of a allergic nature in the 6 month to 2 year old child include eczema, urticaria (which frequently is either food or drug re-

lated), and nonspecific drug induced rashes.

At this age, some symptoms of the allergic tension-fatigue syndrome are also seen.¹¹ The full-blown syndrome is not frequently encountered in this age group, but symptoms of apparently unexplained irritability, stomachache, and headache are sometimes encountered.

The physical examination becomes more helpful in this age group. In addition to the obvious abnormalities noted on examination of the ears, the subtle presence of fluid in the middle ear space is frequently manifested by varying degrees of hearing loss. Dark circles under the eyes, otherwise known as "allergic shiners" are commonly seen in children with allergic upper respiratory illnesses.¹² The gaping or open-mouthed child is one usually afflicted with perennial allergic rhinitis.¹³ Geographic tongue is thought to be associated with food allergy. Allergic asthma, characterized by expiratory wheezing, may be encountered in some children in this age group.

Comments referable to laboratory studies in the birth to 6 month old child are applicable here as well. In addition, an elevated eosinophil count on smear of the nasal discharge is significant in the child over 6 months of age. Impedance tympanometry is a reliable method of testing for the presence of middle ear fluid in this age group. It is especially helpful in the child too young to cooperate in obtaining an audiogram where the presence of middle ear fluid may be manifested by hearing loss.

Radiography of the chest is helpful in the evaluation of the allergic child at this age as well, with aspiration of foreign bodies a possibility as a child begins to crawl, then walk.

Two Years to Six Years

Frequent respiratory illnesses continue to characterize the allergic child in the early childhood years (Table 3). Recurrent ear problems and associated cough are prominent as previously noted. The cough may be associated with upper respiratory illness per se and may also continue as an interval symptom. The children who experience sick winters and well summers begin to emerge as a distinct group, manifesting allergy to house dust and/or molds, to the exclusion of pollens. The incidence of true allergic asthma also seems to increase in this age group.

Gastrointestinal symptoms characteristic of the allergic 2 to 6 year old child are primarily unexplained stomachache and constipation. Other less common findings are diar-

Table 2. Helpful Criteria in Recognizing the Allergic Child from Six Months to Two Years of Age

| | |
|----------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| History | Frequent or continuous upper respiratory illnesses (URI's) Recurrent acute otitis media Serosus otitis media Cough, Craup Wheezing Constipation, Diarrhea Skin Rash |
| Physical Examination | Abnormal tympanic membranes Fluid in middle ear space Enlarged, pale nasal turbinates "Shiners" Hyperthrophic lymphoid tissue, posterior pharynx "Gapers" Geographic tongue Wheezing Eczema |
| Laboratory Studies | CBC Quantitative immunoglobulins (QIG's) Precipitating antibodies to cow's milk Nasal smear Sweat Electrolytes Cultures |
| X-ray Studies | Congenital abnormalities Foreign body |

Table 3. Helpful Criteria in Recognizing the Allergic Child from Two Years to Six Years of Age

| | |
|----------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| History | Frequent URI's, seasonal or perennial Recurrent acute otitis media Serosus otitis media Cough, Craup Wheezing Constipation Skin Rash Headache, Stomachache, Irritability |
| Physical Examination | Abnormal tympanic membranes Fluid in middle ear space Hearing loss Enlarged, pale nasal turbinates Nasal discharge, Postnasal drainage (PND) Nasal crease "Shiners" Hyperthrophy of tonsils/adenoids secondary to PND Gapers, Geographic tongue V-shaped palate Eczema, Urticaria, Angioedema |
| Laboratory Studies | CBC Quantitative immunoglobulins (QIG's) Precipitating antibodies to cow's milk Nasal smear Cultures Allergy skin tests |
| X-ray Studies | Foreign body Atelectasis/bronchiectasis |

rhea, belching, spitting and vomiting. Abdominal distention has been reported as the only finding in one patient with milk intolerance.¹⁴

Skin symptoms may be similar to the younger child, with urticaria and eczema most frequently

Recognizing the Allergic Child

Table 4. Helpful Criteria in Recognizing the Allergic Child from Six Years of Age to Adolescence

| | |
|----------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| History | Runny nose, seasonal or perennial, frequently bloody Cough, seasonal or perennial Wheezing Exercise induced wheezing Constipation Headache, Stomachache, leg ache, tension Skin Rash |
| Physical Examination | Abnormal tympanic membranes Hearing loss, Serous otitis media Enlarged, pale nasal turbinates Nasal crease, Nasal discharge, PND "Shiners" Hypertrophic lymphoid tissue, posterior pharynx Geographic tongue Palate, Dental/facial abnormalities Urticaria, Angioedema Wheezing (reversible bronchospasm) Barrel Chest deformity |
| Laboratory Studies | CBC Quantitative immunoglobulins (QIG's) Precipitating antibodies to cow's milk Nasal smear Cultures Allergy skin tests Exercise testing for exercise induced asthma Pulmonary function studies |
| X-ray Studies | Atelectasis, Bronchiectasis Early emphysema |

seen. Drug-induced rashes continue to appear from time to time. Allergic angioedema begins to appear in this group of children more than previously.

More children with symptoms of the allergic tension-fatigue syndrome are seen in this age group. Headache, otherwise unexplained, and isolated stomachaches are also symptoms which begin to occur more frequently.

Abnormal physical findings noted in younger children are seen as frequently in this age group. Signs of nasal allergy become slightly more prominent in the older child. The nasal crease, a result of constant nasal rubbing in an upward fashion, referred to as the "allergic salute" is frequently seen in children with nasal allergy. Hypertrophic lymphoid tissue may be noted on the posterior pharyngeal wall. Enlarged tonsils and adenoids are frequently seen in allergic children and may be a manifestation of inflammation secondary to nasal allergy and post-nasal drainage. Palate deformities, such as the high arched palate, and malocclusion problems are seen with increasing frequency.

Appropriate laboratory studies to aid in identifying the allergic child in this age group are similar to those discussed previously. Allergy skin tests, although utilized in younger children to some extent, are more reliable as children pass their second birthday.

X-rays are helpful in the child who has a history of recurring pulmonary disease where signs and symptoms are suggestive of atelectasis or bronchiectasis.

Six Years to Adolescence

The older child or adolescent with allergic disease may relate a history of illness as previously described (Table 4). In addition, seasonal rhinitis or bronchitis secondary to pollen sensitivity begins to appear with increasing frequency. Older children and adolescents also may complain of wheezing with exercise or exertion (exercise induced asthma).¹⁵ Complaints of stomachache continue to be a problem, but must now be differentiated from a different variety of illnesses such as appendicitis, pancreatitis, and the like. When no obvious etiology is apparent to explain the stomachache, the child may be thought a malingerer and parents may suspect their children of using this complaint to stay away from school or avoid distasteful tasks. It may be particularly difficult to differentiate gastrointestinal complaints secondary to allergy from those due to an emotional or truly functional etiology such as stomachache or diarrhea before examinations at school, athletic events, and the like.

Angioedema and urticaria are seen with increasing frequency and now must be differentiated from nonallergic causes such as infection, neoplastic disease, collagen disease, endocrine disturbances, and physical factors to mention a few.

The tension-fatigue syndrome in full bloom (so to speak) is manifested in the older child and adolescent. Symptoms characteristic of the allergic tension-fatigue syndrome are unexplained fatigue, nervousness, headache, stomachache, leg and joint ache, and other systemic manifestations. Foods are the most common offender, but other allergens are occasionally incriminated as causative factors in this symptom complex.

Physical examination of the ears may show evidence of previous ear disease with dull or scarred tympanic membranes. The inferior nasal turbinates are frequently enlarged and pale, especially in children with pollenosis. Hypertrophic

lymphoid tissue in the posterior pharynx is seen on examination of the throat. The tonsils and adenoids are noted to be receding in size as commonly occurs with maturation to adolescence.

Wheezing, which clears after administration of inhaled beta 2 agonists, characterizes allergic asthma in this group of children as well. Asthma which has been present and poorly controlled for several years may result in an increased AP diameter of the chest, the so-called "barrel chest" deformity.

Exercise induced asthma may be demonstrated in the laboratory with pulmonary stress testing. This maneuver, incorporating methacholine challenge, is also helpful in identifying the child with asthma when the diagnosis is in doubt or unclear.¹⁶

Pulmonary function studies, when indicated, are also feasible in this age group where the child is old enough to cooperate. Improvement in pulmonary function after administration of bronchodilators is helpful in identifying the child with allergic bronchospasm.

Part II

This next section of the paper concerns a presentation of data on 848 children who were referred for an allergy evaluation because of continuing and recurring respiratory symptoms and other symptoms similar to those discussed in the preceding section of the paper.

The group consisted of 848 children — 597 six years old or less, 251 over six years old (Table 5).

Many of the children had been symptomatic for several years prior to referral. Almost half of the children had symptoms for over 3 years before they were seen for an allergy evaluation (Table 6).

Specific symptoms which these children exhibited in an ongoing and continuing pattern (also known as interval symptoms) were rhinitis, cough, eye symptoms, and wheezing. These symptoms continued in between episodes of more acute illness (Table 7).

Illnesses which were present as part of the past history included bronchitis, pneumonia, asthma, and others as noted in Table 8.

Food intolerance should be suspected when there is a history of any of the following, alone or in combination: (1) Feeding problems in infancy (excessive spitting, vomiting, colic); (2) Problems with stool patterns, either diarrhea or constipation; (3) Vague or unexplained headache, stom-

Table 5. Summary of Histories of 848 Children with Allergic Recurring Respiratory Illnesses

| | Number of Patients |
|-----------|--------------------|
| Age (Yrs) | |
| 6 and < | 597 |
| > 6 | 251 |

Table 6. Summary of Histories of 848 Children with Allergic Recurring Respiratory Illnesses

| Duration of Symptoms (Yrs) | Number of Patients |
|----------------------------|--------------------|
| 0-1 | 198 |
| 1-2 | 198 |
| 2-3 | 113 |
| > 3 | 339 |

Table 7. Summary of Histories of 848 Children with Allergic Recurring Respiratory Illnesses

| Interval Symptoms | Number of Patients |
|-------------------|--------------------|
| Rhinitis | 645 |
| Cough | 651 |
| Eye Symptoms | 198 |
| Wheeze | 221 |

Table 8. Summary of Histories of 848 Children with Allergic Recurring Respiratory Illnesses

| Interval Symptoms | Number of Patients |
|----------------------------|--------------------|
| Bronchitis | 215 |
| Pneumonia | 206 |
| Asthma | 191 |
| Otitis | 459 |
| Fever | 143 |
| Suspected Food Intolerance | 649 |

Table 9. Summary of Laboratory Studies of 848 Children with Allergic Recurring Respiratory Illnesses

| | Number of Patients |
|--------------------|--------------------|
| Serum Eosinophiles | |
| ND* | 165 |
| Elevated | 167 |
| Normal | 516 |
| Nasal Eosinophiles | |
| ND* | 281 |
| Elevated | 202 |
| None | 365 |

* ND = Not Done.

achache, or leg ache; (4) Unexplained fretfulness, restlessness, irritability, tension; (5) Eczematoid dermatitis. In this report, children with these symptoms are listed as suspected food intolerant. In addition, those children whose mothers reported symptoms attributed specifically to foods are included.

The presence or absence of serum and/or nasal eosinophils was not particularly helpful in identifying patients with upper respiratory symptoms secondary to allergy (Table 9).

Recognizing the Allergic Child

Table 10. Summary of Laboratory Studies of 848 Children with Allergic Recurring Respiratory Illnesses

| | Number of Patients |
|-----------------------|--------------------|
| Serum Immunoglobulins | |
| ND* | 231 |
| IgA N**, IgG N, IgM N | 247 |
| IgA↑, IgG↑, IgM↑ | 24 |
| IgA N, IgG N, IgM↑ | 206 |
| All Others | 140 |

* ND = Not Done; ** N = Normol Range.

Serum immunoglobulins were determined in 617 patients. No specific or predictable pattern was noted. In those children where serum immunoglobulins were determined, none were immune deficient (Table 10). (Not included in this report are a group of children with IgA deficiency which we have previously reported.)¹⁷

Skin testing showed that most patients were sensitive to indoor airborne allergens. Over half of the children also showed mold sensitivity. Just over 25% of the children were sensitive to pollens and a similar number gave positive reactions to foods (Table 11).

Results of treatment, noted in Table 12, show that 61 children were managed with avoidance measures for indoor airborne allergens. Of these, 47 (77%) did well. In this report, a good response is defined as one where there are few, if any, symptoms and medication is rarely or never needed. A fair response is defined as improvement, but symptoms occur from time to time and medication is occasionally required. A poor re-

sponse reflects no improvement. Seven hundred seventy-three patients were managed by a program of avoidance of indoor airborne allergens plus diet restrictions. Of these, 582 (75%) had a good response.

Fourteen patients were managed with diet restrictions only. Eleven did well and three showed a fair response.

Thus, of the total, 798, or over 90% of patients became either symptom-free or showed significant improvement.

Table 13 shows the length of time these children have been followed since their initial workup. Routinely, after improvement has been shown to be consistent, only yearly or biyearly follow up visits are recommended. Most patients followed for 2, 3, or 4 years or more are those who need to be reminded from time to time that continuing avoidance measures for indoor allergens is important in maintaining their improvement, or those who also need to be reminded from time to time that problems with foods can continue to be responsible for recurring problems.

Part III

Comments: The data presented in Table 6 is worth another thought. Children who exhibit the same constellation of respiratory symptoms for 2 or 3 years or longer require more than only casual care. An effort must be made to determine the underlying cause for their ongoing problem. Frequently, as discussed earlier, the problem is one of an allergic response.

Children whose symptoms begin early in infancy frequently exhibit their allergic symptoms secondary to food intolerance. A careful history will frequently reveal the food in question and this food should then be removed from the diet on a trial basis. When symptoms have cleared, the food should be reintroduced and should be permanently restricted from the diet only when

Table 11. Summary of Allergy Skin Tests of 848 Children with Allergic Recurring Respiratory Illnesses (Skin Tests Positive)

| | House Dust | Molds | Pollens | Foods |
|--------------------|------------|-------|---------|-------|
| Number of Patients | 586 | 398 | 243 | 281 |

Table 12. Summary of Mode of Treatment and Response in 848 Children with Allergic Recurring Respiratory Illnesses

| | Mode of Treatment | | | Response | | |
|--------------------|-------------------|------------------|-----------|----------|------|------|
| | Avoidance | Avoidance & Diet | Diet Only | Good | Fair | Poor |
| Number of Patients | 61 | 773 | 14 | 47 | 6 | 8 |
| | | | | 582 | 149 | 42 |
| | | | | 11 | 3 | 0 |
| TOTAL | | | | 640 | 158 | 50 |

Table 13. Summary of Follow Up of Treatment and Response in 848 Children with Allergic Recurring Respiratory Illnesses

| Number of Patients | Length of Follow Up (Yrs) | | | | | |
|--------------------|---------------------------|-----|-----|-----|-----|-----|
| | 0-1 | 1-2 | 2-3 | 3-4 | 4-5 | > 5 |
| | 215 | 145 | 157 | 135 | 107 | 89 |

a clear cause and effect relationship can be determined from trial challenges.

Children whose symptoms begin in the fall, continue through the winter and into the early spring, and disappear with the coming of warm weather are frequently children whose allergic response is to indoor airborne allergens. These include house dust, house dust mites, indoor molds, and sometimes animal danders. A large number of allergic children exhibit this pattern of wintertime illness and summertime wellness. Skin testing is probably not necessary to identify these children with allergy to indoor airborne allergens. Based on the characteristic history, appropriate avoidance measures may be recommended with a high likelihood of success.¹⁸ Taking the time to review with the parents the important steps to be taken in eliminating offending allergens from the indoor environment, including specific steps for the eradication of the dust mite, are well worth the physician's time and effort. And, as can be seen from the previous data, something in the range of 90% of the patients with these types of allergy symptoms can be expected to improve significantly when steps such as diet restriction and environmental avoidance of indoor airborne allergens are carried out. The pediatrician or family practitioner is in a unique position to initiate these specific treatment programs without referral to an allergist.

Conclusion

Presented here have been the findings with regards to history, physical examination, lab, and x-ray which are helpful in recognizing the child with allergic disease. Data from over 800 children served to support the suggestions and recommendations made with regards to interpretation of data obtained from the history, from the physical examination, and the laboratory. Perhaps the most helpful aids in identifying the allergic child are a high index of suspicion and a carefully taken history. Be suspicious of allergy when symptoms persist or are recurrent and chronic. Think of URI as upper respiratory illness rather than upper respiratory infection. Children with recurrent or ongoing symptoms are not continuously ill from infections in many instances, but from the data presented here, it is clear that underlying allergy is playing a significant role in the etiology of the illnesses in these children. Take time to be curious. Normal, well infants do not cry and fuss for prolonged periods of time. Normal, well chil-

dren are not sick all winter. Well children do not develop dark circles under their eyes, appear pale, and breathe through their mouths. Well and healthy children do not have unexplained fatigue, nervousness, headache, stomachache, leg and joint ache, and other systemic manifestations.

Children with allergy frequently do not "out-grow" their symptoms, but may actually become worse as they grow older. Recognizing the allergic child and instituting proper modes of treatment is the finest service we can provide to these children.

References

1. Rapaport HG, Linde SM. *The Complete Allergy Guide*. Simon C. Schivster; 1970:13-14.
2. Pollowitz JA. Asthma Management and Managed Care (Editorial). *Asthma Management*. 1994;3:57.
3. Marks MD. Allergy in relationship to orofacial dental deformities in children: A review. *J Allergy*. 1965;36:293.
4. Bresolin D, Shapiro PA, Shapiro GG, et al. Mouth-breathing in allergic children; Its relationship to dentofacial development. *Am J Orthod*. 1983;83(4):334-340.
5. Meredith DM. Airway and dentofacial development. *Am J Rhinology*. 1988;2:33-41.
6. Sampson HA, Albergo R. Comparison of results in skin tests, RAST and double-blind, placebo-controlled food challenges in children with atopic dermatitis. *J Allergy Clin Immunol*. 1984;74:26.
7. Johnston DE. Food allergy in children under two years of age. *Ped Clin N Am*. 1969;16:211.
8. Wilson JF, Heiner DC, Lahey ME. Studies on iron metabolism: milk induced gastrointestinal bleeding in infants with hypochromic microcytic anemia. *JAMA*. 1964;189:568.
9. Fomon SJ, Ziegler EE, et al. Cow milk feeding in infancy: gastrointestinal blood loss and iron nutritional status. *J Ped*. 1981;98:540.
10. Crawford LV. A study of nasal cytology in infants with eczematoid dermatitis. *Ann Allergy*. 1960;18:59.
11. Speer F. The allergic tension-fatigue syndrome. *Ped Clin N Am*. 1954;1:1029.
12. Marks MD. Significance of discoloration in the lower orbitopalpebral grooves in allergic children, "Allergic Shiner." *Ann Allergy*. 1963;21:26.
13. Marks MD. The gaping allergic child. *Ann Allergy*. 1965;23:616.
14. Macfarlane NT. Personal Communication.
15. Ghory JE. Exercise and asthma: Overview and clinical impact. *Pediatrics*. 1975;56(suppl):844.
16. Bierman WC, Kawabori I, Pierson WE. Incidence of exercise-induced asthma in children. *Pediatrics*. 1975; 56 (suppl):846.
17. Jones EA Jr. The response of children with selective IgA deficiency to allergy management programs. *Immunol Allergy Prac*. 1984;6:308.
18. Platts-Mills TAE. Allergen avoidance at home: What really works? *J Resp Dis*. 1989;10:53.

Physicians Needed for County Boards of Health

This is to request your assistance in locating physicians who are interested in serving on Kentucky's county boards of health. The Department relies heavily on the state's practicing physicians to provide guidance to the local health departments as they deal with everything from outbreaks of communicable diseases to environmental health problems. The majority of our clinical preventive medicine services and many of our public health services are designed to improve the health status of women

and children. As a result, we always try to identify female physicians who are interested in serving on the county and district boards of health.

Local boards of health are increasingly being called upon to assist with community based planning as Kentucky responds to changing public-private relationships. It is a challenging time to serve on a board of health. We have been lucky that so many dedicated physicians have served with us over the years. As we move forward, we hope to see more of our female colleagues participate

in the process. Interested physicians, female or male, can let their county health department director know of their interest or can contact me at the Department for Health Services, 275 East Main Street, Frankfort, KY 40621; telephone (502) 564-3970 for details on how to become involved.

Thank you in advance for your assistance.

Rice C. Leach, MD
Commissioner
Cabinet for Health Services

Letters To The Editor

The Editorial Board of the *Journal of the Kentucky Medical Association* welcomes comments, criticisms, recommendations, and observations from all its readers. Please submit letters to:

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Carpal Tunnel Syndrome

Effects of Litigation on Utilization of Health Care and Physician Workload

Morton L. Kasdan, MD, FACS; Michael I. Vender, MD; Kathleen Lewis, BA;
Shawn P. Stallings, MD; J. Mark Melhorn, MD

We performed a study consisting of two parts to investigate the impact of litigation on patient recovery and physician workload. We received 556 replies from a questionnaire sent to hand surgeons and discovered that 98.20% of them felt that litigation increased the subjective complaints of patients. Most of these physicians (89.75%) also felt that litigation led to a worse result from treatment. Second, we undertook a retrospective chart review of 447 patients to see if there was a correlation between litigation, patient utilization of health care and physician workload. We found that workers' compensation patients with pending litigation went to the doctor's office more. They also had more letters, phone calls, and forms associated with their care, had more nerve conduction studies performed, and took longer to be discharged from care than patients with non-work-related carpal tunnel syndrome as well as workers' compensation patients who did not have pending litigation. These results indicated that litigation does affect patient utilization of health care and increases the workload on the physician.

questionnaires to 741 members in active practice listed in the directory of the American Society for Surgery of the Hand. We asked them two questions regarding their views on this hypothesis. We received 556 replies. We then conducted a review of 447 records from three different practices in three different cities to determine if there was indeed a more labor intensive problem for the physician with compensable patients.

Compensation is shown to be a barrier to patient recovery in a number of studies.^{2,5} Financial gain supplied through disability payments appears to reward a patient for being injured.^{2,3} Patients have been found to have a decreased chance of successful outcome from surgery if they have pending litigation.⁴ Millender indicates that physicians are frustrated because of the difficulty in rehabilitating patients who have pending litigation and because of the increased workload they encounter.⁶ These concerns have prompted this study of the problems with compensation. Our paper demonstrates the effects of litigation on utilization of health care and physician workload.

Dr Kasdan is a Clinical Professor of Surgery, University of Louisville School of Medicine, and a Clinical Professor in the Department of Preventive Medicine & Environmental Health, University of Kentucky College of Medicine; Dr Vender is affiliated with Hand Surgery Associates, SC, Arlington Heights, IL; Dr Stallings is affiliated with the University of Louisville School of Medicine; Dr Melhorn is a Clinical Assistant Professor in the Department of Surgery, Section of Orthopaedics, University of Kansas School of Medicine-Wichita.

Materials and Methods

In the first part of our investigation, 741 questionnaires were sent to members in active practice from the ASSH that asked two questions: (1) With regard to rehabilitation of the injured worker, how do you feel litigation (a tort or workers' compensation case) affects the subjective complaints of most patients? (2) How do you feel litigation (a tort or workers' compensation case) affects the eventual outcome of conservative treatment and/or surgery? Five hundred fifty-six questionnaires were returned to us.

Second, we performed a retrospective chart review of 447 cases from 1978 to 1994 to determine the effects of litigation on patient utilization

Pending litigation for patients has been regarded not only as a cause of increasing financial concern to industry, but also a cause of an increased workload for physicians treating injured workers and an obstacle to patient recovery. With work-related carpal tunnel syndrome estimated to represent 47% of all cases of carpal tunnel syndrome, problems with compensation and litigation could have a profound effect on industry, the worker, and the physician.¹ We hypothesized that secondary gain impedes patient recovery and causes an increased workload for the physician.

In the first part of our investigation, we sent

Carpal Tunnel Syndrome

Table 1

| | Number of Cases |
|---------------------------------------------------------------------------------|-----------------|
| Total Cases | 447 |
| Non-Work-Related Cases (Non-WKC) | 154 |
| Workers' Compensation Cases (WKC) | 159 |
| Workers' Compensation Cases with Pending Litigation (WKC with Litigation) | 126 |
| Tort Cases | 8 |

This table shows the total number of cases reviewed broken down into four categories: (1) cases not related to work, (2) work-related cases without pending litigation, (3) work-related cases with pending litigation, and (4) tort cases. Records were obtained from three different hand surgeons' practices in three different cities; 102 come from one office; 206 come from a second office; 139 come from a third office.

of health care and workload on the physician. We obtained a random selection of charts for patients who had undergone carpal tunnel surgery. Of these 447 cases, there were 287 females and 160 males. Charts from three physicians' practices in three different states were used. One hundred two cases came from one office, 206 were from the second office, and 139 were from the third office. One hundred fifty-four of the 447 cases (34.45%) were not attributed to work. One hundred fifty-nine cases (35.57%) were felt to be work-related by the surgeon without pending litigation. One hundred twenty-six cases (28.19%) were assigned as work-related with pending litigation; that is, patients in this group had filed formal complaints with the aid of an attorney. Eight of

the 447 cases (1.78%) involved tort litigation (Table 1).

Using a survey worksheet, we obtained the following information for each case: the number of preoperative and postoperative visits; the number of nerve conduction studies; the number of telephone calls, letters, and forms completed by the doctor's office; the number of subjective complaints at the last visit and the number of weeks after surgery that the patient continued to be seen. The information was divided into four groups: cases that were not related to work, tort cases, workers' compensation cases with pending litigation, and workers' compensation cases without pending litigation. The assignment of "work-relatedness" of the patient's disorder as a possible result from work was the decision of the treating physician. Carpal tunnel syndrome was considered to be unrelated to work if the patient was unemployed, not working at the time of injury or onset of symptoms, or the job was not thought to be causally related. We then compared the information in each of the four groups to determine the effect of litigation on patient utilization of health care and physician workload.

Results

For the first part of our study, 98.20% of the physicians surveyed felt that litigation increased the subjective complaints of patients. Litigation was felt to adversely affect surgery results by 89.75% of the respondents (Table 2).

In the second part of our study, we noted that workers' compensation patients with pending litigation went to the doctor 53.52% earlier after the initial onset of symptoms than patients with non-work-related carpal tunnel syndrome. Patients with tort cases went to the doctor 35.43% sooner than the non-work-related cases. Work-related cases with pending litigation had 37.27% more preoperative visits than non-work-related cases. Tort cases had 30.67% more preoperative visits than non-work-related cases (Table 3).

Workers' compensation patients who had pending litigation had 45.39% more complaints following surgery, 44.98% more postoperative visits to the physician, and took 34.57% longer to be discharged from the physician's care than patients who were not receiving workers' compensation. Workers' compensation patients with pending litigation had 42.76% more complaints, 32.73% more postoperative visits, and took 27.08% longer to be discharged than did worker's com-

Table 2

| | No Effect On Subjective Complaints | Increases Subjective Complaints | Decreases Subjective Complaints |
|---------------------------------------------------------------|------------------------------------------|---------------------------------------|---------------------------------------|
| How Does Litigation Affect Subjective Complaints? | 10 | 546 | 0 |
| How Does Litigation Affect Treatment Outcome? | No Effect 57 | Better Results 0 | Worse Results 499 |

This table represents the response to our survey of physicians from the American Society for Surgery of the Hand. We received 556 responses out of 741 surveys.

pensation patients who did not have pending litigation (Table 4).

Workers' compensation patients with pending litigation had 48.18% more telephone calls, 70.43% more outgoing letters, 80.25% more outgoing forms, and 45.19% more nerve conduction studies than patients not receiving workers' compensation (Table 5).

Discussion

The incidence of carpal tunnel syndrome has been reported to be ten times higher in the workplace (in a cross-sectional study) than in the general population.¹ If workers' compensation and litigation are problems in treating patients, these issues could have a drastic effect on industry, the worker, and the physician. Several studies in the literature demonstrate the increased cost to industry due to compensation claims.⁶⁻¹² The financial burden of work-related disorders has been estimated at \$14 billion a year.⁸ Musculoskeletal and nerve disorders are the fastest growing workplace concerns and have been estimated to affect 10% of industry workers.⁹ Centineo estimated the cost of pending litigation for a single employee being compensated for a work-related illness or injury at \$19,500, a price which includes workers' compensation payments, settlement costs, medical costs, and the cost of finding a replacement while the injured employee is off work.¹⁰ An average of 19.7 lost days per work-related disorder has been estimated.⁹ Furthermore, the increased workload on physicians who treat injured workers, along with the frustration of dealing with these patients' psychosocial issues, complicates the recovery of the injured worker.^{6, 11, 12}

In comparing the results of the four different groups in our study, the numbers certainly indicate a connection between pending litigation, barriers to patient recovery, and increased workload on the physician. Most of the physicians we surveyed echoed the feelings of other doctors in the literature: that patients with pending litigation have more subjective complaints and have a decreased chance of optimal outcome from treatment.^{4, 6, 7, 11, 12} Strasberg et al report that a patient's chance of successful outcome, judged by either subjective improvement or return to work, was significantly less if the patient had pending litigation.⁴ Higgs et al found that patients in a workers' compensation program had more residual symptoms and a decreased chance of returning to gainful employment than other patients.⁷

Table 3

| | Average Weeks from Onset to First Visit to Physician | Preoperative Visits | |
|---------------------|------------------------------------------------------|---------------------|---------|
| | | Total For Group | Average |
| Non-WKC | 144.42 | 754 | 4.68 |
| WKC, No Litigation | 103.53 | 1844 | 5.76 |
| WKC with Litigation | 67.13 | 955 | 7.46 |
| Tort | 93.25 | 54 | 6.75 |

Non-WKC = cases not related to work; WKC = workers' compensation cases; WKC With Litigation = workers' compensation cases with pending litigation.

This table shows (1) the average number weeks between the onset of symptoms and the first visit to the doctor and (2) the total number of preoperative visits for each group.

Table 4

| | Average Number of Post-Op Visits | Average Number of Weeks of Post-Op Treatment |
|---------------------|----------------------------------|----------------------------------------------|
| Non-WKC | 5.48 | 40.02 |
| WKC | 6.70 | 44.60 |
| WKC with Litigation | 9.96 | 61.16 |
| Tort | 5.75 | 55.63 |

Non-WKC = cases not related to work; WKC = workers' compensation cases; WKC With Litigation = workers' compensation cases with pending litigation.

This table shows the average number of post-operative visits and the average number of weeks of treatment following surgery.

Table 5

| | Phone Calls | Letters | Forms | Nerve Studies |
|---------------------|-------------|---------|-------|---------------|
| Non-WKC | 4.84 | 2.70 | 2.84 | 1.48 |
| WKC | 5.75 | 5.15 | 7.25 | 1.87 |
| WKC with Litigation | 9.34 | 9.13 | 14.38 | 2.70 |
| Tort | 7.5 | 3.75 | 10 | 2.5 |

Non-WKC = cases not related to work; WKC = workers' compensation cases; WKC With Litigation = workers' compensation cases with pending litigation.

This table shows the average number of telephone calls, outgoing letters, outgoing forms and nerve conduction studies.

That litigation is a barrier to patient recovery is evident in several ways. First, patients with pending litigation had an average of 4.48 more postoperative visits to the physician and had 21.14 more weeks of follow-up treatment than patients whose cases were not related to work. They had an average of 3.26 more postoperative visits and 16.56 more weeks of follow-up treatment than compensated patients who did not have pending litigation. These patients had 45.39% more subjective complaints following surgery than non-work-related patients and 42.76% more than compensated patients who did not have pending litigation.

The increased workload on physicians is also

Carpal Tunnel Syndrome

evident from this study. Patients with pending litigation had 48.18% more telephone calls than non-work-related patients and 38.44% more than compensated patients who did not have pending litigation. The physician had to write an average of 6.43 more letters and fill out 11.54 more forms for a compensated patient with pending litigation than for a patient whose carpal tunnel syndrome was not work-related. Workers' compensation patients with pending litigation had 45.19% more nerve conduction studies than non-work-related patients and 30.74% more than compensated patients who did not have pending litigation.

Our study demonstrates a relationship between litigation, patient utilization of health care, and physician workload: excess medical utilization, increased work load on the physician and physician's staff per patient, and less than optimal outcome from treatment.

References

1. Cummings K, Maizlish N, Rudolph L, Dervin K, Ervin A. Occupational disease surveillance: carpal tunnel syndrome. *MMWR*. 1989;38:485-489.
2. Gice JH. *Risk Management*. 1988;62-65.
3. Dworkin RH, Handlin DS, Richlin DM, Brand L, Vannucci C. Unraveling the effects of compensation, litigation, and employment on treatment response in chronic pain. *Pain*. 1985;23:49-59.
4. Strasberg SR, Novak CB, Mackinnon SE, Murray JF. Subjective and employment outcome following secondary carpal tunnel surgery. *Ann Plast Surg*. 1994;32:485-489.
5. Derebery VJ, Tullis WH. Delayed recovery in the patient with a work compensable injury. *JOM*. 1983;25:11:829-835.
6. Millender LH. Occupational disorders — the disease of the 1990s: a challenge or a bane for hand surgeons. *J Hand Surg*. 1992;17A:193-195.
7. Higgs PE, Edwards D, Martin DS, Weeks PM. Carpal tunnel surgery outcomes in workers: effect of workers' compensation status. *J Hand Surg*. 1995;20A:3:354-360.
8. Lahey JW. Bearing down on musculoskeletal disorders. *NSNews*. 1983;37-39.
9. Occupational Hazards. 1987;45-47.
10. Centineo J. Return-to-work programs: cut costs and employee turnover. *Risk Management*. 1986;44-48.
11. Martin RD. Secondary gain, everybody's rationalization. *JOM*. 1974;16:12:800-801.
12. Dobyns JH. Role of the physician in workers' compensation injuries. *J Hand Surg*. 1987;12A:5:826-829.

Information for Authors

Manuscripts — Articles will be accepted for consideration with the understanding that they are original and are contributed solely to this *Journal*. The transmittal letter should designate one author as correspondent and include the author's address and telephone number. Receipt of manuscripts will be acknowledged and unused manuscripts returned. All material is reviewed by the Board of Editors and publication of any article is not to be deemed an endorsement of the views expressed therein.

Preparation — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

Copyright assignment — In view of The Copyright Revision Act of 1976, effective January 1, 1978, transmittal letters to the editor must contain the following language and must be signed by all authors: "In consideration of *The Journal of the Kentucky Medical Association* taking action in reviewing and editing my submission, the author(s) undersigned hereby transfers, assigns, or otherwise conveys all copyright ownership to *The Journal* in the event that such work is published by *The Journal*."

References — References must be typed in double spacing on separate sheets and numbered consecutively as they are cited. They should include (in this order) the authors' names and initials, title of article (and subtitle if any), abbreviated name of journal, year, volume number, inclusive page numbers. Follow the AMA style currently in use, abbreviating the names of journals in the form given in *Index Medicus*. Authors are responsible for reference accuracy.

Illustrations — Illustrations must be submitted in duplicate and the sequence number and author's name should appear on the back of each. Legends for illustrations should be typewritten (double-spaced) on a separate sheet. The author will be billed for the cost of reproduction of illustrated material for publication in excess of three average illustrations and/or tables. Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source.

Editorials and Letters — Should be written in clear, concise language. Length should be about two pages typed with double spacing. Letters will be published at the discretion of the Editorial Board.

Reprints — Reprints are available at an established schedule of costs. Order forms are sent to all authors at the time of publication.

The Bright Side

After the patients leave, the phone calls are answered, and the papers sorted, I spend the last minutes at my desk attempting to bring a close to the day. Some days recently have been corrupted by the dealings with third party payers, with new regulations and requirements, and with difficult personalities.

The call at 7:10 PM punctuated my silence, and the nurse at the other end sounded troubled. Her patient, Mrs R, came to her care covered with skin problems, making both of them scared. After a convoluted story about many medications, radiation, and a terrible menacing tumor, I interrupted and agreed to come right over to the hospital. After I clutched my instruments under my arm, I made my way thinking what could be wrong, and how tired I was looking out at the dark sky through the hallway window. This "lady in the hospital" would demand my concentration, despite any fatigue or irritability built up from another day on the front line.

I found Mrs R straddling the side of the bed, with red legs and face catching my eyes immediately. Her worried and inquisitive daughter sat by her side, helping with the history and carefully comparing me to my predecessors that day. Mrs R chronicled her problem clearly and vividly, until I had information enough to start talking. I scrutinized her skin, touching the elevations, noticing the colors, finding the cracks, and weighing the differences in each area. When I asked to use my instruments to sample her skin, she quickly consented, but braced for another violation after many that day. Finally I stopped the doing part, to our cumulative relief, and took my seat at the bed's edge to unravel the

story. My audience of two, mother and daughter, followed my explanation and watched my hands, each part designed to clarify, not mystify. I connected the radiation induced painting erythematous red on her chest and the mimicking on a much smaller scale of the rest of her lesions. That her medication and immune weakness participated was no surprise, understood by that all too familiar shaking the heads in unison.

Once her situation had an explanation, I wrote in front of these witnesses my plans for relief. Such simple applications as cool compresses, less washing, and mild topical medicaments seemed antiquated in a room decorated with medicine's finest. Nevertheless, I reflected that "less" sometimes can be better and that my watching would allow time to heal or reason to act more aggressively. My mood that evening wanted to be gentle, and my patient and her daughter seemed relieved that I could leave their room with a smile, a handshake, and a last touching of the skin that the staff seemed loathe to contact.

Next day Mrs R was much better, I was rested and the medical world felt peaceful. My staff then told me that Mrs R had a managed care plan, with which I did not participate. I admitted to not even looking at the front of the chart for that piece of paper, reflecting that not many years ago I never looked for that paper!! In the new perfect managed care world, the admitting physician should somehow find out who was "in" and who "out." This real world at 7:10 PM plays out no such performance, and neither of us considered that new variable.

That evening I took the same

walk as before, hoping that the world outside the window would still be light, but again nothing but the silver moon on black. This time, when I opened the door, Mrs R sat in the same position hanging feet from the bed, but with light pink, not red, skin and an infectious smile. She sat with cancer in her brain and chest, but with skin now acceptable to be viewed and touched, not feared. Her daughter replaced her earlier worried frown with a partial smile, happy for the evolution, but knowing the bad days still ahead. For now, we conversed about the change for the better, the incipient discharge, and the return to her own house. I took my seat again at the foot of the bed, in a row with my patient. I told the insurance story, like the politician explains his impotence, and accepted the blame for any financial burdens. Without a delay, Mrs R now took my hand and touched my skin, saying nice things about my care and dismissing my concerns about her responsibilities. She worked hard on the land many years, saved and invested, and could pay me for helping her. I pressed her hand back and said that she had helped me also. She gave me that chance once again to doctor, to soothe, to help, to treat and to comfort that enriches those of us who can live and work in medicine. She excised that demon for just a little while, that business side of medicine that none of us can escape.

My trip back down the hallway was better this time, even though it was late and I was hungry. Yes, the sky was still black, but my eyes were bright and so was my heart.

Stephen Z. Smith, MD



Ruth Ryan

Attending a planning meeting last October for Growing Healthy were (seated L to R) Barbara Marshall, field director for AMAA, and Marla Vieillard, 1995-96 KMAA president. Standing L to R: Shyla Gowdar, publicity; Renuka Reddy, member PCMAA; Carolyn Daley, president PCMAA; Anne Gilbert; Kaye Florence; Sharmila Shankar, president-elect PCMAA; Hala Malek, Legislation Committee.

BRAVO! PERRY COUNTY!

PERRY COUNTY MEDICAL ASSOCIATION ALLIANCE received a coveted Health Awareness Promotion Award at the American Medical Association Alliance Annual Convention in Chicago on June 23, 1996, for the county's planned comprehensive health education program called *Growing Healthy*. Perry County Alliance members, under the dynamic leadership of their 1995-1996 President, Carolyn B. Daley, are in the process of raising in the Hazard community approximately \$25,000 to implement the program in the school year beginning August 1996. Many Perry County physicians support this project, giving their money to help seed it and committing their time in the classrooms.

Developed by the National Center for Health Education, the Growing Healthy Program is designed to promote self-esteem and decision-making skills and enable young adults

to adopt healthy, responsible attitudes and behaviors. Aimed at students in grades K-6, the program addresses not only the physical, but also the emotional and social dimensions of health. The curriculum helps children confront today's pressing health issues such as substance abuse, HIV/AIDS, teen pregnancy, and violence/injury/abuse.

Today more than 9,000 schools across the United States, with a total of more than one million school children, reap the benefits of Growing Healthy, making it the leading program of its type. Unlike single-topic curricula, Growing Healthy incorporates 42 to 56 lessons per grade level on issues ranging from disease prevention, family life and health, substance abuse, and nutrition to personal health, consumer health, community and environmental health, mental/emotional health, and human growth and development.



Many Growing Healthy activities encourage parents to be active participants, and even classroom volunteers. Before each new phase of Growing Healthy, teachers send letters home explaining what the students are about to learn.

It is an honor to be associated with such dedicated physicians' spouses, who undaunted by the prospect of raising such a formidable sum of money to fund the Growing



Top: PCMAA member Kaye Florence volunteered in the "SAVE Today" project at Walkertown Elementary School in Hazard.

Center: A reception/fund-raiser for Growing Healthy held at the home of Dr Fitz and Anne Gilbert raised \$1700 plus commitments for several thousand more dollars. Community leaders and medical staff members were invited. Hazard Mayor Bill Gorman (far right), and Nan Gorman (second from left) are supporting the Alliance's effort to bring Growing Healthy to Hazard schools. Pictured with the Gormans are Carolyn Daley, Shyla Gowdar, and Sharmila Shankar.

Bottom: Shyla Gowdar, in front of class at right, presented a "SAVE Today" workbook to students at Walkertown Elementary.

Healthy Program, are determined that through their efforts, the children in their community will achieve critical thinking skills relevant to healthy lifestyles and even influence their parents in such decision making.

Should other medical associations and/or alliances choose to emulate the Perry County group, you may obtain information about the Growing Healthy Program from them and/or from the National Center for Health Education, 72 Spring St, Suite 208, New York, NY 10012-4019; Telephone 212/334-9470; FAX: 212/334-9845.

Ruth Ryan
KMAA President



1996

OCTOBER

18-20 — Diagnostic Radiology, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323-5161 or FAX 1/606/323-2008.

19 — Neurology for Primary Care Provider, Radisson Plaza, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323-5161 or FAX 1/606/323-2008.

27-31 — 1996 State-of-the-Art Conference — "Managed Care and Occupational Medi-

cine: the Next Generation," Toronto, Ontario, Canada. Sponsored by the American College of Occupational and Environmental Medicine. Contact: Kay H. Coyne, ACOEM, 55 W Seegers Rd, Arlington Heights, IL 60005-3919; phone 708/228-6850, FAX 708/228-1856.

NOVEMBER

1-3 — Diabetes Conference, New Developments in the Pathogenesis & Treatment of NIDDM (non-insulin dependent diabetes mellitus); Radisson Resort, Scottsdale, AZ; sponsored by the American Diabetes Association of Arizona and the National Institute of Diabetes and Digestive and Kidney Dis-

eases. Contact: American Diabetes Assoc, Arizona Affiliate, Inc, 2328 W Royal Palm Rd, Ste D, Phoenix, AZ 85021; phone 602/995-1515; FAX 602/995-0004.

10-15 — 27th Annual Family Medicine and Primary Care Review, Hyatt Regency, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323-5161 or FAX 1/606/323-2008.

21-22 — Perinatal/Neonatal Symposium, Lexington, KY. Contact: University of Kentucky Office of CME; 1/800/204-6333; 606/323-5161 or FAX 1/606/323-2008.

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BAPTIST HEALTHCARE SYSTEM

William P. VonderHaar, MD Named Citizen Doctor of the Year

William P. VonderHaar, MD, Louisville, was named Citizen Doctor of the Year by the Kentucky Academy of Family Physicians during its 45th Annual Scientific Assembly in Louisville. The award is the highest honor the Academy bestows upon a deserving member nominated by his or her peers each year.

Dr VonderHaar has served as Speaker of the KAFP Congress of Delegates since 1982 and on numerous committees of the Academy and the Jefferson County Medical Society.

His service to the Kentucky Medical Association is exemplary. He currently serves as Secretary-Treasurer and chairs the KEMPAC Board. Committee obligations include Continuing Medical Education, National Legislative Activities, Legislative Quick Action, Awards, and Joint Oversight Group on Health Care Reform.

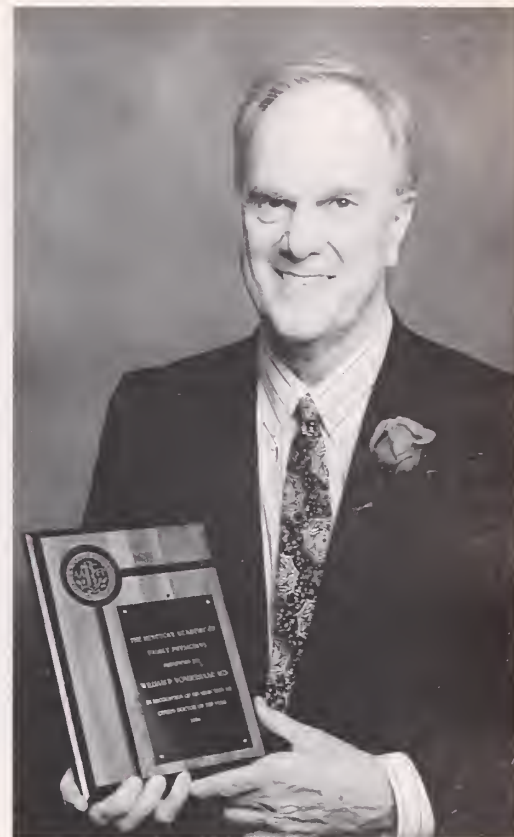
Currently serving as clinical professor, Department of Family Practice at the University of Louisville, Dr VonderHaar has devoted many years to teaching medicine. In 1988 he received KMA's prestigious Educational Achievement Award.

Dr VonderHaar's community activities have included serving as chair of the Catholic and Jefferson County School Boards; Jefferson County Board of Health; Metro United Way Committees; and Boards of the American Cancer Society, Kentucky Division; Visiting Nurse Association;

Community Action Commission; among others. He was twice named City of Louisville "Distinguished Citizen."

The Kentucky Academy is a chapter of the American Academy of Family Physicians (AAFP), the largest medical specialty group in the United States with more than 70,000 members.

KMA extends sincerest congratulations to Dr VonderHaar for this richly deserved honor.



Many of Dr VonderHaar's family members and friends surprised him by attending the awards presentation, kept secret until the time of the event. All eight of his children were there to see their father honored. A daughter made the longest trip — from Hawaii.



Robert G. Cox, KMA's CEO Honored With KHA Award of Excellence

Robert G. Cox, KMA Executive Vice President, was honored with the Kentucky Hospital Association's (KHA) Award of Excellence during its Annual Convention. This prestigious award is granted to a deserving individual who has demonstrated noteworthy service in a health related field for activities above and beyond the usual and customary.

Bob Cox has served Kentucky medicine 35 years, 28 of them as Chief Executive Officer of the Kentucky Medical Association. He was recognized for this service and the outstanding relationship enjoyed by the KHA and KMA, both on the officer and staff level. These Associations have worked closely on numerous political and professional issues confronting the health care sector.

During the presentation, comments highlighting the many

contributions Bob Cox has made to the medical community included:

"Mr Cox has been a major proponent and firm believer in the need of hospitals, represented by KHA, and physicians, represented by KMA, to work hand-in-hand in order to preserve the rights of patients. He has always recognized the need for the two organizations to present a unified front, particularly in the legislative and political arena.

"His leadership and dedication to the medical and health care community will certainly transcend his impending retirement. On behalf of Kentucky hospitals, our sincere gratitude for the contributions you have made over the past 35 years. It is with deep respect and gratitude that we present you with the Association's Award of Excellence."

KMA

PEOPLE



Gilbert H. Friedell, MD, director for cancer control at the University of Kentucky Markey Cancer Center, has received two prestigious national awards and a certificate of appreciation for his contributions to the field of cancer control.

Dr Friedell received the Calum S. Muir Memorial Award for Outstanding Contributions in the Field of Cancer Registration from the North American Association of Central Cancer Registries. He also was awarded the Leffall/White Award for Cancer Prevention and Control Research in Underserved Populations by the American Association for Cancer Research and the Intercultural Cancer Council, and a Certificate of Appreciation by the American Cancer Society for his support of the creation of the Centers for Disease Control's National Program of Cancer Registries.

Director of the nationally praised Kentucky Cancer Registry, Dr Friedell co-directs the Kentucky Cancer Program. He also is principal investigator of the National Cancer Institute's Cancer Information Service, which is based in Lexington at the Markey Cancer Center and covers Kentucky, Tennessee, and Arkansas. Dr Friedell is the author of numerous professional articles on cancer and is

chair of the Steering Committee of the Appalachia Leadership Initiative on Cancer, sponsored by the National Cancer Institute.

After receiving his undergraduate and medical degrees from the University of Minnesota, Dr Friedell taught pathology at Harvard University Medical School, Boston University School of Medicine, and University of Massachusetts Medical School. He has been at UK since 1983.

Walter L. Olson, Jr, MD, neurology, and **Virginia T. Keeney, MD**, departments of psychiatry and behavioral sciences and family and community medicine, were among a group honored at the recent University of Louisville annual Community Service Luncheon. Dr Olson was nominated for work with the Kentucky chapter of the Huntington's disease Society of America. Dr Keeney was nominated for service to the American Red Cross spanning more than 53 years.

KMA members included in a recent list of faculty promotions at the University of Louisville School of Medicine were **Eleanor D. Lederer, MD**, renal medicine, associate professor; **Ronald I. Paul, MD**, pediatrics, associate professor; **David H. Taylor, MD**, psychiatry and behavioral sciences, assistant professor.

UPDATES

Brown Cancer Center Honors Founder

The James Graham Brown Cancer Center honored one of its originators, **Condict Moore, MD**, at a Founders Day celebration marking the center's 15th anniversary.

According to a U of L report, the center was built on a foundation of research and discovery dating back to the 1950s, and cancer advances pioneered here include:

— The Pap Smear (1956). **William Christopher, MD**, developed its effective use as a diagnostic tool and initiated the Louisville Pap smear program. Only the second of its kind in the world, it eventually resulted in worldwide use of the test.

— follow-up chemotherapy for breast cancer patients (1961). **Rudolph Noer, MD**, then chair of surgery, pioneered the addition of an anti-cancer medication program following breast cancer surgery.

— mammography as a diagnostic tool.

— research on smoking related cancers in patients who stopped smoking. Dr Moore's research (1965-1971) showed that cancer patients who were former smokers developed no new smoking cancers (mouth, throat, lungs, for example), while one-third of cancer patients who continued to smoke developed new cancers.

— free-flap plastic surgery to repair the ravages of head and neck cancers, pioneered in the early 1970s by **Robert D. Acland, MD**, and **Michael B. Flynn, MD**. Both remain active medical school faculty members.

— protection for workers exposed to cancer-causing chemicals. After a commonly used rubber manufacturing agent was found to be carcinogenic, **Carlo H. Tamburro, MD**, professor of environmental medicine, developed programs to contain a predicted cancer epidemic and improve the health monitoring of chemical workers.

— hormone receptor screening to determine breast cancer therapy. **James L. Wittliff, MD**, director of U of L's Hormone Receptor Lab, studies the relationship between hormones and hormone-dependent cancers (of the breast and uterus, for example).

He developed tests to determine whether women with breast cancer might benefit from hormone therapies.

— Louisville's cancer researchers, including Brown Cancer Center scientists, participated in the first clinical studies to establish the use of tamoxifen as an auxiliary treatment for breast cancer. Findings led to the world's first clinical drug trial of a possible breast cancer preventative.

Dr Moore and other U of L researchers united in the early 1970s to capitalize on funding possibilities presented by the National Cancer Act of 1971. U of L's long-range plans for a center were accelerated in 1977 when the Regional Cancer Corp organized and raised within a year \$12 million to build a cancer treatment and research center.

City government donated land and the James Graham Brown Foundation, in its largest gift of that time, donated \$5 million to the project. That's how the center got its name.

Professor's Gift Establishes Psychiatry Chair at U of L

Gisela E. Kolb, MD, a University of Louisville psychiatrist and professor emeritus, has given \$1.5 million to the university's psychiatry and behavioral sciences department.

Dr Kolb has established the Gottfried and Gisela Kolb Endowed Chair in Outpatient Psychiatry, in part to honor her late husband, Germany's first child psychologist, who died in 1970.

The occupant of the chair will teach, conduct research, and supervise the care of indigent patients.

A German-trained psychoanalyst, Dr Kolb practiced in Berlin until her husband's death. She came to the United States to study at the Southern Indiana Mental Health Center. After

further study in New York, she joined the faculty at the U of L Kent School for Social Work in 1973, then moved to the university's psychiatry department and a position at Louisville General Hospital's outpatient psychiatric center.

She said her motives for establishing the chair include fond memories of experiences at the hospital and her commitment to indigent psychiatric care. She also called the gift an expression of her gratitude to the United States for its efforts on behalf of her native city, Berlin.

Dr Kolb served on the psychiatry department faculty during a period of expansion of its residency program. She directed the resident curriculum area and for 14 years she was vice director of its training program.

She was twice winner of the Golden Apple Award, presented annually by residents of the department to the person they consider the best teacher, and received a rare "instructor" designation from the American Group Therapy Association.

Drug Abusers and Doctor Shoppers

Recently, the KMA Board of Trustees discussed the issue of drug abusers obtaining narcotic prescriptions from physicians. It was noted that some Medicaid patients have a history of fraudulently obtaining prescriptions from physicians and "shopping" doctors to obtain prescriptions from several different physicians.

Rice C. Leach, MD, Commissioner, Department for Health Services, reported that physicians should contact the Drug Control Branch of the Department for Health Services if Medicaid patients are suspected of fraudulently obtaining prescriptions from physicians.

Physicians can contact the Drug Control Branch at 502/564-7985.

UNISYS Update

The UNISYS recoupment process will continue in a changed format over the next several weeks. For those physicians still owing Medicaid over \$5000 from the interim payment process (Medicaid advises that there are 234 physicians in this category), Medicaid will contact you to work out an individualized recoupment plan that is considerably less than the current 85%/15% recoupment rate. Those physicians owing less than \$5000 from the interim payment process will still be subject to the 85%/15% recoupment rate.

If you are still experiencing problems with UNISYS and its processing of your Medicaid claims, you are encouraged to call the Lieutenant Governor's office at 502/564-2611 or Medicaid at 502/564-2687 to voice your concerns.

National Medical Malpractice Survey

The median medical malpractice award for 1995 climbed to \$500,000. According to a recently released study by the Jury Verdict Research Series, the median award marks an increase of approximately 40% from 1994, when the median award was \$356,000.

The study calculated the highest median medical malpractice award was for child birth cases, at \$1.3 million. The median award for medication-related negligence was \$621,000. For misdiagnosis the median award was \$508,000. Awards for surgical neglect, non-surgical treatment, and doctor/patient relations cases had a median of approximately \$250,000.

Wrongful death cases accounted for 21% of the verdicts in 1995, while severe brain damage was second with 5%. Emotional distress accounted for 4% of the verdicts while mild to moderate brain damage and paralysis each accounted for 3%.

Between 1990 and 1995, 85% of all malpractice settlements were for more than \$100,000, 43% of settlements were for more than \$500,000, and 22% were for more than \$1,000,000. At the extreme, 2% of settlements were for more than \$5,000,000.

The median length of time from an alleged act of negligence to trial was over 60 months.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Carroll

Winston Y. Yap, MD — PD
309 11th St, Carrollton 41008
1988, U of Alberta, Canada

Fayette

Craig A. Banta, MD — N
280 Stone Rd, Lexington 40503
1980, U of Kentucky

Elio D. DeMeira, MD — N
135 E Maxwell Ste 310, Lexington 40508
1968, Universidad Federal de Santa Maria, Brazil

Saroj B. Dubal, MD — AN
280 Stone Rd, Lexington 40503
1970, G. S. Medical College, India

Michael R. Grimmer, MD — OPH
2183 Stonewood Ln, Lexington 40509-4423
1986, U of California, Irvine

James E. O'Neill, MD — OBG
1780 Nicholasville Rd Ste 202, Lexington 40503
1973, U of Kentucky

Akintokunbo B. Owuoye, MD — IM
1401 Harrodsburg Rd Ste B-160, Lexington 40504
1982, U of Ibadan, Nigeria

Timothy S. Prince, MD — PM
Kentucky Clinic, Lexington 40504
1986, Emory U, Atlanta

Craig M. Zavelo, MD — IM
1221 South Broadway, Lexington 40504
1978, State U of New York, Syracuse

Franklin

Christopher D. Clopton, MD — R
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DEATHS

Warren M. Cox, MD
Louisville
1928-1996

Warren M. Cox, MD, a retired psychiatrist, died April 11, 1996. A 1954 graduate of New York University School of Medicine, Dr Cox was a life member of KMA.

Frank Whalen, Jr, MD
Harrodsburg
1939-1996

Frank Whalen, Jr, MD, a family practitioner, died April 29, 1996. Dr Whalen was the physician for the Harrodsburg-Mercer County Health Department and a former Mercer County coroner. A 1965 graduate of the University of Louisville School of Medicine, Dr Whalen was an active member of KMA.

Earl W. Roles, MD
Louisville
1905-1996

Earl W. Roles, MD, a retired orthopedic surgeon, died April 30, 1996. Dr Roles graduated from Hahnemann Medical College of Philadelphia in 1932 and was a life member of KMA.

Wyatt Norvell, MD
New Castle
1915-1996

Wyatt Norvell, MD, a retired family practitioner, died May 18, 1996. Dr Norvell was a 1941 graduate of the University of Louisville School of Medicine and served KMA in numerous capacities, including Vice President, Vice Chair and Chair of the Board of Trustees, and Senior Delegate. In 1976, Dr Norvell was recipient of KMA's highest honor, the Distinguished Service Award. He helped establish the Kentucky Rural Health Council, and influenced state government to establish standards and to inspect nursing homes. Dr Norvell was a life member of KMA.

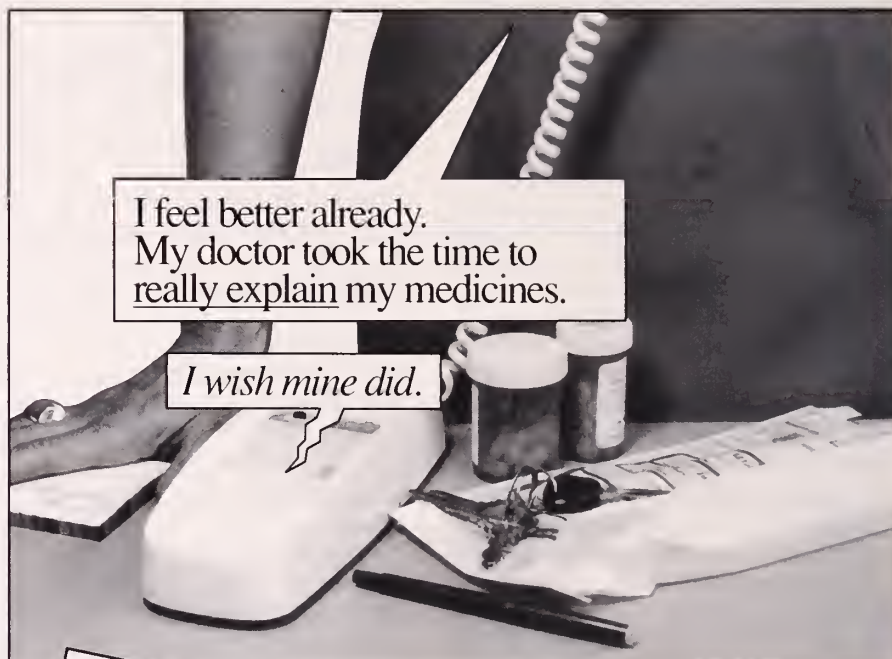
Herbert L. Clay, Jr, MD
Falls of Rough
1916-1996

Herbert L. Clay, Jr, MD, a retired cardiologist, died May 20, 1996. A 1939 graduate of the University of Louisville School of Medicine, Dr Clay was a life member of KMA.

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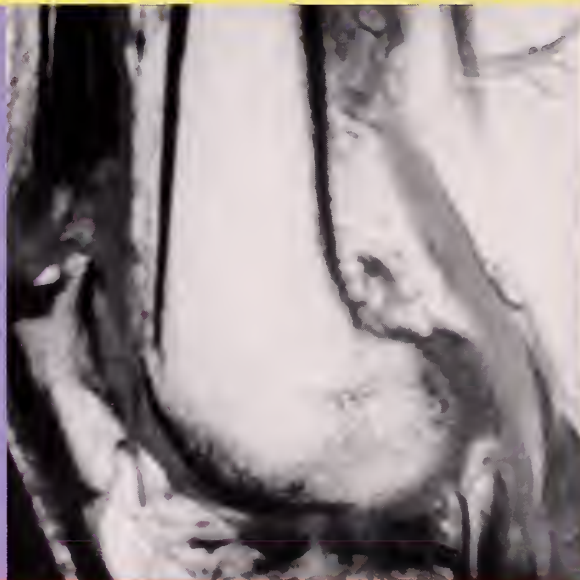


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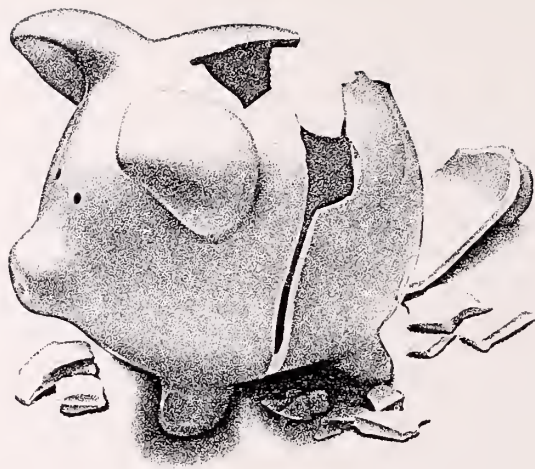
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| SCIENTIFIC | Carotid Endarterectomy in a Community Hospital <i>Sibu P. Saha, MD; Anthony G. Rogers, MD; Gary F. Earle MD; Craig Nachbauer, MD; Mary Baker, RN, MSN/MHA</i> | 314 |
| EDITORIAL | Mentors <i>Daniel W. Varga, MD</i> | 319 |
| ASSOCIATION | <i>Monitoring Medicine</i> | 309 |
| | Annual Meeting Preliminary Program | 323 |
| | KMA Annual Meeting Exhibit Guide | 354 |
| | C. Kenneth Peters, MD, Nominated KMA President-Elect | 363 |
| DEPARTMENTS | President's Page | 307 |
| | Advertisers' Guide | 372 |
| | Alliance Page | 321 |
| | Classifieds | 369 |
| | Information for Authors | 316 |



COVER: The KMA Annual Meeting provides a focal point for Kentucky Physicians on the spectrum of medical issues and challenges facing them. "Quality Care in an Age of Efficiency" is the theme of this year's meeting, scheduled for Wednesday through Saturday, September 25-28, at the Hyatt Regency Hotel/Commonwealth Convention Center in Louisville. This month's cover introduces a complete preliminary program for this not-to-be-missed event. You will also find in these pages a pull-out section containing an abridged schedule of events and maps for your convenience in locating meeting and parking facilities. Mark your September calendar for KMA's premier educational event!

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Danny M. Clark, MD

The Future Is in Our Midst

Soaring medical costs, perceived excess of providers, and private sector's movement to control expenses have led to major innovations in the health insurance market — and consequently to the practice of medicine. HMOs, PPOs, self-insured, employers and other various economic entities have emerged as primary regulators of the health marketplace displacing physicians and government. Managed care, and resulting patient decisions made "from afar," often without medical input and routinely and shockingly without simple understanding of common medical terms, has created an atmosphere of anxiety and frustration among both patients and physicians.

The KMA has conducted ongoing studies of health insurance mechanisms including Preferred Provider Organizations (PPOs). PPOs are networks of providers who agree to furnish medical care for a particular group at preset fees. Patients may choose their physician even if their physician does not

participate. However, the patient is responsible for additional costs if the provider is nonparticipating and PPOs routinely pay patients if they are treated by nonparticipating providers. The KMA Physician Organization Study Committee, under the capable leadership of Bob Goodin, MD, has been our principal educator on changes in the health insurance marketplace and reporting and recommending to the Board of Trustees and the House of Delegates action or response to these changes.

It is within this context that your KMA Board of Trustees met in special session on June 20, 1996, to consider a proposal that KMA form a PPO. This request had previously been considered and approved by both the Physician Organization Study Committee and the Executive Committee.

The purpose of the special Board of Trustees meeting was to hear a proposal from Preferred Health Choice (PHC) to work with KMA to establish a physician-directed preferred provider organization which

would have the potential of serving the Kentucky Kare program. The Kentucky Kare program is the state's self-insured program for state employees. Currently, the program utilizes a contracted hospital network, but to date has paid physicians on a fee-for-service basis without a participating provider agreement. The state has advised Preferred Health Choice and others that it intends to add a physician preferred provider organization component to the program at its October 1996 enrollment period to become effective January 1997. Participating physicians within the PPO would agree to accept Kentucky Kare fees as payment in full with no balance billing. The Kentucky Kare program will not require providers to assume any risk or to use "gatekeepers."

Kentucky Kare payment rates are set by the state and the payment rate to physicians would be the same regardless of the entity named as the PPO.

Mr Tony Pino, CEO, and other PHC representatives, presented a

general outline of the group's experience, current activities in Kentucky, as well as ongoing cooperative efforts with the South Carolina and Mississippi State Medical Associations. The proposal is for KMA, or a wholly owned KMA subsidiary, to provide physicians services through an administrative structure of KMA's choice. KMA would define provider credentialing requirements, solicit members to become participating physicians, and appoint a medical director.

Under the proposed set up PHC would:

- Develop provider agreements, assist KMA in provider recruitment, provide staff and equipment for support services, and develop orientation programs for providers and their staffs.
- Produce provider enrollment packets, manuals, operating plans and procedures, and utilization reports.
- Be responsible for all marketing tasks, including meetings with state employees to explain the program and provide information on participating physicians. Finalize a state employee complaint/grievance procedure as required by the state.
- Be responsible for processing claims and developing a cash management program.
- Be responsible for all management reports, client enrollment, hardware

and software requirements, and other reporting structures required by the state.

There appeared to be unanimous consent among members of the KMA Board that if Kentucky physicians are to maintain some semblance of control of their own practices, that the formation by the Association of a statewide PPO was strongly indicated. The Board recommended to the House of Delegates that KMA pursue the formation of a PPO to service the Kentucky Kare self-insurance plan in cooperation with Preferred Health Choice, Inc, pending the development of an agreement satisfactory to the Board.

Recognizing a need for an immediate decision and action to meet forthcoming deadlines relating to the Kentucky Kare program, the Board directed the Executive Committee to:

- Conduct a survey of interest of KMA members.
- Direct attention to proposed organizational structure, including consideration of tax status, Board of Directors, Medical Director, committees, etc.
- Develop a participating physician agreement.
- Pursue an agreement with Preferred Health Choice, Inc.
- Solicit Participating Agreements at the appropriate time.
- Determine if a special meeting of the House of Delegates is needed.

As of this writing, the survey has been mailed and responses are being returned. Other directives are being pursued by the Executive Committee and you will be continually updated on these activities. Ultimately, changes in medicine including managed care and various provider and nonprovider economic entities, know no barriers. Whether we practice in the inner city or in the country — whether surgical or nonsurgical — insurance contracts generally remain the same. Only rarely are patients or physicians granted exceptions from contract language.

Eric Hoffer once said, "It is a paradox that in our time of drastic change, when the future is in our midst devouring the present before our eyes, we have never been less certain about what is ahead of us." Members must make their own individual decision based on practice location, personal and professional needs, and above all, how best to serve their patients. All of us are relatively new to this process. No one, at least that I am aware of, has all the answers. Therefore, we urge each of you to become educated on these and other concepts as the transformation of medicine continues. Your comments and suggestions are sincerely solicited.

Danny M. Clark, MD
KMA President

MONITORING MEDICINE

NEWS FOR KENTUCKY PHYSICIANS

The Kentucky Board of Medical Licensure, in cooperation with the KMA Ad Hoc Committee to Study Guidelines for Prescribing Controlled Substances, has developed the following guidelines.

Guidelines for Prescribing Controlled Substances

The guidelines outlined below were formulated from various sources and literature. They are offered to assist physicians in safe and appropriate decision making in prescribing controlled substances.

I. Diagnosis. Establish a working diagnosis based on an adequate history, physical examination, and appropriate diagnostic tests.

II. Management Plan. Formulate and document a plan of treatment. Make appropriate referrals if needed for optimum diagnosis and management.

III. Eliminate Alternatives. Before beginning a regimen of controlled drugs, document that other measures and drugs have been inadequate or not tolerated.

IV. Be Aware of Drug Seekers. Learn drug seeking behaviors and obtain personal and family histories of chemical dependency.

V. Informed Consent. Document that patient has acknowledged that he/she has been advised of the risks of the proposed treatment. Family conferences may be helpful to establish ground rules.

VI. Monitoring. Maintain regular monitoring of the patient and his progress. Consider "drug holidays" to monitor compliance and continued need.

VII. Control. Make sure that you are in control of the drug supply. Keep detailed records. Assure that one physician orders the medications and one pharmacy fills all

prescriptions. In most cases require the patient to return for refill authorization.

VIII. No Self-prescribing. Physicians should studiously avoid prescribing to self, immediate family, or staff.

IX. Anorectic Drugs. Avoid the use of Schedule III and IV anorectic drugs.

X. Muscle Relaxants. Prescribe muscle relaxants with caution on a chronic basis, particularly those with known addictive potential. Examples include, but are not limited to, carisoprodol (Soma) and diazepam (Valium).

XI. Anxiolytic Drugs. Use as much caution with addictive anxiolytic drugs as with opioid drugs.

XII. Common Problems. Be aware of common problems faced by physicians who come under investigation:

- (1) Inadequate records/documentation.
- (2) Failure to document diagnosis (pain is a symptom, not a diagnosis)
- (3) Prescribing controlled substances without a trial of alternative treatments
- (4) Failure to monitor side effects of drugs, and
- (5) Failure to document rational reason for chronic use of controlled substance.

KMA

A. GENERAL GUIDELINES. These are simple, general recommendations for the safe and proper use of prescription drugs with abuse potential.⁵

"It's not important what you prescribe but how well you manage the patient's care and create a record of that care"

I. Diagnosis. First and foremost before prescribing anything, establish a diagnosis which is supported by adequate history and physical examination and the results of appropriate diagnostic tests. Unfortunately it is often found that a symptom, rather than a diagnosis, is the basis for a given treatment.

II. Management Plan. Formulate a treatment plan that includes appropriate non-addictive modalities. Make referrals to appropriate specialists, if necessary, to establish the diagnosis and insure that alternative treatment modalities are tried. Include all correspondence and test results in the patient's chart. One such management plan¹ follows:

1. Determine if patient has had an adequate trial of a non-drug regimen of treatment (exercise, physical therapy, behavior modification, etc) and if not, initiate such a regimen.
2. Prescribe non-narcotic analgesics, such as NSAIDs, acetaminophen, Midrin, non-habituating muscle relaxants, or Ultram (if still listed as a nonscheduled agent).
3. Prescribe weak opioids (propoxyphene, Talwin, codeine, oxycodone).
4. Prescribe stronger opioids (morphine, Demerol, Dilaudid, etc).
5. Combinations of any of the above may be indicated, even from the beginning.

III. Eliminate Alternatives. Before beginning a regimen of controlled drugs, make a determination through actual clinical trial or through patient records and history that non-addictive regimens have been inadequate or are unacceptable by comparison, eg, intolerance or allergy to nonsteroidal anti-inflammatory drugs. The assertion by a patient that a certain narcotic, eg, Percodan, works well for him/her is not an adequate history of failure of other methods or drugs. Too often physicians who have come under review have instituted treatment with potent opioids apparently without ever considering other forms of treatment. "How much is too much?" is a question often asked. No agency will be able to answer that question specifically. Validity of treatment must be established case by case and by the quality and content of the diagnostic and therapeutic regimens implemented.

IV. Be Aware of Drug Seekers. Make sure you are not dealing with a drug seeking patient. If the patient is new or otherwise unknown to you, obtain, at a minimum, an oral drug history, and discuss chemical use and family chemical history with the patient. If you have any doubts, you may consider obtaining a chemical dependency evaluation prior to prescribing a potentially addictive substance.

V. Informed Consent. Before prescribing a potentially addictive drug, assure that the patient has an understanding of the relative risks and benefits of the drug, based on relevant published literature, eg, PDR, AMA Drug Evaluations, USP DI. It may be beneficial to obtain written informed consent in selected patients. When the possibility of long term use of potentially addictive substances exists, it may be helpful to educate the family to the risks and benefits of the medication. One effective mechanism to accomplish this may be holding a family conference. The refusal of a patient to permit a family conference may be a red flag alerting the physician to potential addictive tendency.

VI. Monitoring. Maintain regular monitoring of the patient, including regular and frequent updating of the history and physical evaluation. Adequate monitoring may include:

1. History update
 - a. Assessment of compliance
 - (1) Are medications being taken as prescribed?
 - (2) Is patient adhering to/cooperating with alternative non-addicting modalities?
 - (3) Record compliance with time frame (asking for refills before time, "losing" doses of prescriptions, trying to use other physicians or pharmacies).
 - (4) Record when told to return and when refills may be made.
 - b. Document patient's response to treatment (improved? worse?).
 - c. Document alterations or additions to the management plan.
2. Physical update
 - a. Vital signs, particularly weight in patients receiving anorectics or narcotics.
 - b. General appearance (does habitus suggest pain, anxiety, depression?).
 - c. Specific signs — pertinent to the individual patient, eg, improved or decreased range of motion.

VII. Control. Make sure that you are in control of the drug supply. To do this, at a minimum keep detailed records of the type, dose, and amount of the drug prescribed. **You** must monitor, record, and control all

refills. One way to accomplish this is to require the patient to return to obtain prescriptions. Routine call-in of prescription drugs is to be avoided. The physician should keep a chronological drug log of controlled substances, eg, a flow sheet. Communicate with other treating physicians and the patient's pharmacist. The patient should use one physician and one pharmacy for his/her controlled substance prescriptions. If either changes, the other should be notified.¹

VIII. Self-prescribing. Physicians should avoid prescription of any controlled substance or any drug with addictive potential to self, immediate family, or staff. No prohibitive laws to that effect exist, as far as the committee is aware. However the recommendation is offered to prevent any appearance of impropriety.⁸

IX. Anorectic Drugs. Avoid the use of Schedule III and IV anorectic drugs. If the mechanism is in place to adequately assess, monitor, and control the short term use of anorectics and physicians wish to enter that therapeutic arena, then the following criteria should be followed.²

1. Prior to initially prescribing any Schedule III or IV anorectic:
 - (a) Obtain a thorough medical and weight loss or gain history;
 - (b) Perform a complete physical examination;
 - (c) Determine that the patient is a medically obese adult;
 - (d) Require the patient to make a substantial good-faith effort at weight reduction, under the physician's supervision, without utilizing drugs;
 - (e) Provide the patient with a carefully prescribed diet, together with counseling on exercise, nutrition, and other appropriate supportive therapy.
2. To appropriately prescribe anorectics the physician should:
 - (a) Ask the patient whether he/she has currently or previously obtained or used anorectics from one or more practitioners, and record the answer.
 - (b) Ascertain whether the patient has a history or potential of abuse of drugs, including alcohol.
 - (c) Rule out conditions contradicting the use of anorectics, including but not limited to pregnancy, hypertension, or hypersensitivity or idiosyncrasy to the drugs.
 - (d) Advise the patient of the drug's potential for abuse, and the possibility of leading to dependence.
 - (e) Consider the possibility that the patient will obtain the drug for a nontherapeutic use or distribution to others, and that there is an illicit market for such drugs.

3. A physician should not normally prescribe a Schedule III or IV anorectic drug to any patient:
 - (a) In a daily dosage greater than the maximum FDA approved dosage recommendation; or
 - (b) For an aggregate period in excess of 120 days during any 12 month period.
4. A physician should not institute or continue the prescription of Schedule III or IV anorectic drugs if:
 - (a) The patient is not a proper candidate for the use of anorectics;
 - (b) The patient has developed tolerance to the appetite suppressant effect of the drug or has experienced euphoria followed by irritability or depression; or
 - (c) The patient has engaged in excessive use, misuse, or abuse of the anorectic, or has otherwise consumed or disposed of the drug(s) other than in strict compliance with the directions and indications for use given by the physician.

It should be noted that lay literature has been disseminating misinformation about certain anorectics. Touting them as "new" and not having abuse problems, phentermine and fenfluramine have been presented to the public by various publications. Standard pharmacy and medical reference works^{3,4} identify them along with the rest of the following as having marked abuse potential:

Amphetamines and their derivatives
 Dextroamphetamine and d. sulfate (Dexedrine,
 Biphentamine) **Cii**
 Phendimetrazine (Bontril et al) **Ciii**
 Mazindol (Sanorex) **Civ**
 Fenfluramine (Pondimin) **Civ**
 Phentermine (Fastin, Ionamin, Adipex) **Civ**
 Benzphetamine (Didrex) **Ciii**
 Methylphenidate (Ritalin) **Cii**

(This list is for your convenience; it is not presented as all-inclusive).

X. Muscle Relaxants. Certain muscle relaxants should be prescribed with the same caution as opioids and other controlled substances. Carisoprodol (Soma) is metabolized to meprobamate, which is known to be addictive. Diazepam (Valium), sometimes used as a muscle relaxant, also has addictive potential.


XI. Anxiolytic Drugs. Controlled anxiolytic drugs (benzodiazepines in particular) should be used with as much caution as opioid drugs. The same common sense guidelines listed elsewhere should be followed. Functional status and quality of life issues should be examined. Avoid treating subjective complaints. The quality of the initial evaluation, documented follow-up visits, consultations, and

alternative treatment and medications, are more important than the absolute amount of the medication given.

XII. Common Problems. Problems faced by physicians when coming under review and investigation by the Board of Licensure and other entities, such as governmental agencies or civil litigation, include:

- (1) Inadequate records/documentation.
- (2) Failure to establish a diagnosis. Subjective complaint of pain is not a diagnosis, it is a symptom.
- (3) Utilizing controlled substances in treatment without alternative methods having been explored and exhausted.
- (4) Failure to monitor the side effects of a drug, eg, monitoring for potential indicators of drug addiction.
- (5) Failure to document why the continued use of controlled substance(s) is necessary.

REFERENCES

1. Kennedy LD. Personal communication.
2. Guidelines for prescribing amphetamine, amphetamine-like and anorectic controlled substances (schedule III and IV). Kentucky Board of Medical Licensure Newsletter. Spring 1994.
3. *Physicians Desk Reference*. Medical Economics Co. Montvale, NJ. 1996.
4. *DI for Providers*. US Pharmacopeial Convention. Silver Springs, MD. 1995.
5. Management of prescribing. Minnesota Board of Medical Examiners Update. Fall 1990. 1-5.
6. Portnay RK. Pharmacologic management of chronic pain. In: Fields H, ed. *Pain Syndromes in Neurology*. Butterworth Heinemann Publisher; Ch 11.
7. Fields H, Liebeskind E, eds. Opioid therapy for chronic nonmalignant pain: current status. In: *Pharmacological Approaches to the Treatment of Chronic Pain: New Concepts and Critical Issues, International Association for the Study of Pain: Progress in Pain Research and Management*. JASP Press; 1994: Vol 1. Ch 16, pp 247-287.
8. Self-prescribing and prescribing to immediate family members. Kentucky Board of Medical Licensure Newsletter. Fall 1991.
9. Elements of a good medical record. Kentucky Board of Medical Licensure Newsletter. September 1992.
10. Guidelines on physical examinations by physicians, adapted by the Kentucky Board of Medical Licensure. Kentucky Board of Medical Licensure Newsletter. March 15, 1990.
11. Portnay R, ed. Special section on pain and addiction. *J Pain & Symptom Management*. 8:5 253-305. July 1993.
12. Portnay R, ed. Adjunctive analgesics in pain management: part II. *J Pain & Symptom Management*. 9:7 423-453. Oct 1994. 



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Carotid Endarterectomy in a Community Hospital

Sibu P. Saha, MD; Anthony G. Rogers, MD; Gary F. Earle, MD;
Craig Nachbauer, MD; Mary Baker, RN, MSN/MHA

From the Division of
Thoracic & Cardiovascular
Surgery, Central Baptist
Hospital, Lexington, KY.

Despite the popularity of carotid endarterectomy, considerable debate remains regarding the appropriateness of these procedures. Critics of carotid endarterectomy cite the excessive morbidity and mortality associated with these procedures, particularly when performed in a community hospital setting. A retrospective study of 130 procedures, involving 124 patients within a medium size community hospital setting, was conducted. Indications for the procedure, associated comorbidities, and complication rates were reviewed. The incidence of stroke with subsequent mortality was 0.8% within the study group. One patient (0.8%) developed acute coronary insufficiency and underwent coronary artery bypass surgery. Five (4.0%) other patients experienced minor complications.

Carotid endarterectomy is a proven prophylactic measure against the prevention of stroke in a selected group of patients. This study reinforces that this procedure may be performed in a community hospital setting with very low morbidity and mortality rates.

Stroke, despite decreasing mortality rates, remains the third leading cause of death in the United States.¹⁻³ This decline in mortality is thought to be due to many factors, including improved management of hypertension and preventative surgery, such as carotid endarterectomy. The popularity of carotid endarterectomy has risen as a mechanism to reduce the incidence of transient ischemic attacks (TIAs) and prevent the consequences of permanent neurological deficit or stroke. Considerable debate remains, however, regarding the appropriateness of these procedures.^{4,5} Multiple clinical trials, such as the North American Symptomatic Carotid Endarterectomy Trial (NASCET), have been initiated in an effort to resolve these controversies.⁶⁻⁸ One of the major criticisms of carotid endarterectomy includes excessive morbidity and mortality associated with

this procedure, particularly when performed in a community hospital setting.^{5,9,10} This retrospective study reflects our experience with 130 procedures in a medium size community hospital setting.

Clinical Material

A total of 124 patients underwent 130 carotid endarterectomy procedures. The patients' ages ranged from 51 to 95 years with an average age of 74. There were 52 men and 72 women in this group. Associated comorbidities (Table 1) included diabetes mellitus, hypertension, coronary artery disease, tobacco abuse, and renal dysfunction. Indications for the procedures (Table 2) included hemispheric transient ischemic attacks, transient monocular blindness, non-hemispheric transient ischemic attack and asymptomatic critical carotid artery stenosis. All patients underwent duplex scanning and Digital Subtraction Angiography (DSA) prior to surgery. In addition, many

Table 1. Associated Comorbidities

| Comorbidity | Percent of Incidence |
|-------------------------|----------------------|
| Diabetes Mellitus | 35 |
| Hypertension | 50 |
| Coronary Artery Disease | 30 |
| Tobacco Abuse | 80 |
| Renal Dysfunction | 23 |

Table 2. Indications for Procedure

| Indication | Incidence |
|-----------------------------------------------|-----------|
| Hemispheric TIAs | 103 |
| Transient monocular blindness | 11 |
| Non-hemispheric TIA | 6 |
| Asymptomatic critical carotid artery stenosis | 10 |

of these patients had a CT scan of the brain. Non-invasive assessment of cardiac function, including echocardiography and Adenosine Thallium Testing, were also performed.

Operative Technique

All of the procedures were performed under general anesthesia. EKG, blood pressure, and EEG were monitored continuously. Thirty percent of the patients had selective use of a Swan-Ganz catheter. Two patients (1.6%) had intraoperative use of a carotid shunt during their procedure. The average cross clamp time was 14 minutes. There were five complications (Table 3). One patient developed a massive stroke postoperatively and subsequently expired, resulting in less than 1% mortality. Two patients experienced transient facial numbness. One patient developed acute coronary insufficiency and underwent successful coronary artery bypass surgery. Two patients developed hematomas requiring reexploration and one patient developed aspiration pneumonia.

Discussion

Several national studies and trials have concluded that carotid endarterectomy provides the best protection against stroke for symptomatic patients with high grade stenosis ranging from 70% to 99%.⁶⁻⁸ Specific criticisms have been raised, however, regarding the high morbidity and mortality often associated with the performance of this procedure in a community hospital. Current preliminary trial results indicate that mortality and morbidity rates should be less than 3% for the maximum benefits of these procedures to be obtained.¹¹ The mortality rate observed within our clinical experience demonstrates that this procedure may be performed safely and effectively within a community setting.

The indications for the performance of carotid endarterectomy have also been heavily criticized. It has been widely accepted that patients with TIA, amaurosis fugax, and critical stenosis should undergo this preventative operative procedure. Other indications, which are now accepted with reservations, include hemispheric stroke with good recovery and minimal to moderate neurological deficit and global ischemic symptoms with multiple arterial occlusive lesions. Controversies continue to exist, however, regarding the following indications: asymptomatic large carotid ulceration, asymptomatic moderate carotid

Table 3. Complications

| Complication | Percent of Incidence |
|-------------------------------------|----------------------|
| Severe stroke with subsequent death | 0.8 |
| Transient facial numbness | 1.6 |
| Acute coronary insufficiency | 0.8 |
| Wound hematomas | 1.6 |
| Aspiration Pneumonia | 0.8 |

artery stenosis, carotid artery disease with progressive intellectual impairment with demonstrable multiple arterial occlusive lesions, acute stroke within the first few hours of occurrence, stroke in evolution or waxing and waning deficit, or vertebrobasilar symptoms with combined carotid and vertebrobasilar disease.¹² In addition, other concerns continue regarding the management of this disease process. These concerns include the role of balloon angioplasty, thrombolytic therapy, laser angioplasty, treatment for stroke in evolution, tandem lesions, and the benefit of extracranial or intracranial bypass grafting.

Finally, clinical competency is felt to be essential to obtain satisfactory outcomes.¹¹ It is believed that a surgeon must perform a minimum of 12 carotid endarterectomies annually with a morbidity and mortality rate of less than 3% for the last 50 cases to ensure surgical quality.

Conclusion

Stroke remains a major health hazard in the United States and carotid endarterectomy is a proven prophylactic measure against stroke in a select group of patients. This procedure can be performed, therefore, in a community hospital setting with a very low morbidity and mortality rate.

References

1. Musser J, Nicholas GG, Reed JF. Death and adverse cardiac events after carotid endarterectomy. *J Vasc Surg.* 1994; 19:615-622.
2. Neville RF, Calcagno D. Symptomatic carotid artery disease: Current management recommendations. *Am Fam Physician.* 1993;48:1059-1066.
3. Zelkovic M, Nicholas GG. Carotid endarterectomy in symptomatic patients. *Heart Dis Stroke.* 1993;2:313-316.
4. Cohen SN, Hobson RW, Weiss DG, Chimowitz M. VA Cooperative Study 167 Group. *J Vasc Surg.* 1993;18:1002-1011.

Carotid Endarterectomy

5. De Bord JR, Marshall WH, Wyffels PL, Marshall JS, Humphrey P. Carotid endarterectomy in a community hospital surgical practice. *Am Surg.* 1991;52:627-632.
6. North American Symptomatic Carotid Endarterectomy Trial Collaborators. Beneficial effect of carotid endarterectomy in symptomatic patients with high-grade carotid stenosis. *N Engl J Med.* 1991;445:453.
7. European Carotid Surgery Trialists' Collaborative Group. MRC European carotid surgery trial: Interim results for symptomatic patients with severe (70-99%) or with mild (0-29%) carotid stenosis. *Lancet.* 1991;337:1235-1243.
8. Veterans Administration Cooperative Study. Role of carotid endarterectomy in asymptomatic carotid stenosis. *Stroke.* 1986;17:534-539.
9. Gertler JP, Blankensteijn JD, Brewster DC, et al. Carotid endarterectomy for unstable and compelling neurological conditions: Do results justify an aggressive approach? *J Vasc Surg.* 1994;19:32-42.
10. Mattos MA, Hodgson KJ, Londrey GL, et al. Carotid endarterectomy: operative risks, recurrent stenosis, and long-term stroke rates in a modern series. *J Cardiovasc Surg.* 1992;33:387-400.
11. Segal HE, Rummel L, Wu B. The utility of PRO data on surgical volume: The example of carotid endarterectomy. *Qual Rev Bull.* 1993;19:152-157.
12. Hobson RF, Weiss DG, Fields WS, et al. Efficacy of carotid endarterectomy for asymptomatic carotid stenosis. *N Engl J Med.* 1993;328:221-227.

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Preparation — Manuscripts should be typewritten in double spacing throughout, including references, tables, legends, quotations, and acknowledgments. Submit the original and one copy, retaining a copy for proofreading. Ordinarily articles should not exceed 3,000 words in length. Titles should include the words most suitable for indexing the article, should stress the main point, and should be short. A synopsis-abstract must accompany each manuscript. The synopsis should be a factual (not descriptive) summary of the work and should state the problem considered, methods, results and conclusions.

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Mentors

"It is imperative that we use chance or planned encounters to instill in young doctors our reverence for our profession and our care for those we attend."

This *Journal* has recently received and accepted for publication several articles examining the issues surrounding new physician career choice. Why does a resident select academic medicine? Why does a physician choose a generalist career? What impacts geographic site of practice? At the risk of oversimplifying the content of excellent papers, it strikes me that in the final analysis these decisions are highly influenced by where they come from, how they are taught, and their impression of what their new life holds. Of these, the second is perhaps where we as a profession have the greatest potential for impact and have often been remiss in exerting our influence.

An incoming medical school class is a diverse population with respect to geography, age, undergraduate degree, exposure to medicine, family situation, and a host of other potentially important demographic characteristics. Almost all will, however, describe some encounter with a physician as an important influence in their decision to pursue medicine as a career. More importantly, many describe their own experience with their personal physician as pivotal to their perception of what it means to be a doctor. Whether that encounter was in the context of personal illness or illness of a loved one, their impressions of the physician took deep root and became long-lived and influential.

Many students will also report that their career choice once in medical school was overwhelmingly

influenced by the physicians they encountered. They became a general surgeon because a surgeon they encountered made medicine in general and surgery in specific a dynamic, fulfilling, and caring vocation for them. While traditionally these experiences have by logistical design been largely with the academic medical community, the changing face of medicine and medical education is moving more of the medical school experience into the community and into the sphere of the full-time practicing physician. Medical students and residents will be encountering us on a daily basis, regardless of whether we are generalists or specialists, urban or rural, actively involved in their teaching or not. It is imperative that we use these chance or planned encounters to instill in these young doctors our reverence for our profession and our care for those we attend.

Too frequently we grouse about the problems of medicine in our age and long for some time past when we were happier with our profession. Surely, as we were being educated our mentors were confronting equally daunting dilemmas. Yet, we came away from our time with them convinced of the wisdom of our decision to pursue medicine and inspired to advance the profession they had revealed to us. Let us hope that the young physicians of today and the future will take the same from us.

Daniel Varga, MD

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KMA ALLIANCE FALL BOARD MEETING

September 27, 1996
Hyatt Regency Hotel
320 West Jefferson Street
Louisville KY40202

*7:30 AM-11:00 AM Registration in second-floor lobby
*7:30 AM-4:00 PM Alliance hospitality suite open

***8:30-10:50 AM in Regency South Ballroom A**

COMBINED COMMITTEE MEETINGS

ALL MEMBERS of the following committees will meet as a group, beginning at 8:30 AM, with each committee allotted a maximum of 20 minutes:

| | |
|---------------------|-----------|
| AMA-ERF | Planning |
| Health Promotion | Finance |
| Legislative Affairs | Executive |
| Membership | |

***11:00 AM-2:00 PM in Regency South Ballroom B**

WORKING LUNCHEON/FALL BOARD MEETING:

*2:00-3:00 PM in Regency South Ballroom B:
two committees will meet separately:

Nominating Committee
Bylaws Committee



Ruth Ryan

“All members are welcome to participate in any and all parts of this program!”

If you have questions, please contact KMAA Fall Board Chairmen:

Mrs Melvin Crispin (Cynthia), 11632 Paramount Way, Prospect KY 40059; 502/228-8004; or
Mrs J. Matthew Schwab (Marie), 4 Arden Road, Glenview KY 40025; 502/426-0744; FAX: 502/429-6346; or
KMAA President, Mrs John J. Ryan (Ruth), 1400 Willow #1606, Louisville KY 40204-1467; 502/454-3302;
FAX: 502/454-5118.

Please note that the KEMPAC dinner is the evening before the KMAA Fall Board Meeting and the KMA President's luncheon is the day after the KMAA Fall Board Meeting.

By September 3, 1996, please make your room reservation with the Hyatt Regency Hotel; specify the KMA/KMAA rate of \$76 single or \$86 double.

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By September 23, 1996, please send your luncheon reservation form with a check for \$15 payable to the Kentucky Medical Association Alliance to:

Mrs Robert Goodin (Carol), 3012 Lighthouse Road, Louisville KY 40222; 502/426-5017.

LUNCHEON/FALL BOARD RESERVATION FORM

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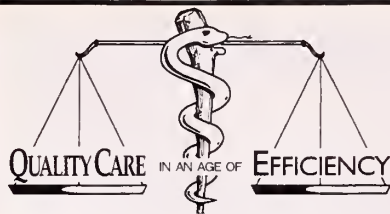
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PRELIMINARY PROGRAM



KMA Annual Meeting • Sept 25 - 28 • Hyatt Regency
Commonwealth Convention Center • Louisville, KY

1996



Contents

| | |
|--------------------------------------------------|---------|
| Official Call | 325 |
| KMA Officers for 1995-96 | 326-328 |
| District Trustee Map | 330 |
| Journal Editors | 329 |
| Elections | 332 |
| Reference Committee Activity | 333 |
| KMA Delegates | 334 |
| Special Features | 341* |
| Abridged Schedule of Annual Meeting Events | 337* |
| Map of Hyatt Regency Hotel | 338* |
| Map of Downtown Louisville | 339* |
| Parking Map | 340* |
| KEMPAC Program | 362 |
| James W. Kincaid, MD, 1859-1933 | 344 |
| Introducing the Guest Speakers | 342 |
| Scientific Program | 345 |
| General Sessions Learning Objectives | 352 |
| Exhibit Hall Floor Plan | 354 |
| Exhibitor Directory | 355 |
| Technical Exhibits | 356 |

** For your convenience these pages are in a special pull-out section.*

Official Call KMA Annual Meeting

To the officers and members of the component and county medical societies of the KMA.

Meeting Place

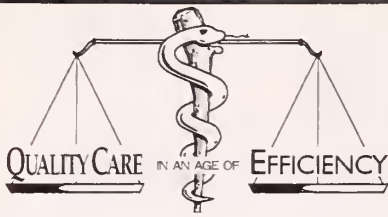
The Annual Meeting of KMA will convene on Thursday, Friday, and Saturday, September 26, 27 & 28, at the Hyatt Regency Hotel and Commonwealth Convention Center, Louisville. The first General Session will be called to order at 8:30 AM, Friday.

The House of Delegates

The first regular meeting of the House of Delegates will convene at 9:00 AM, Thursday, September 26, in the Regency Ballroom, located in the Hyatt Hotel. The second regular business meeting will begin at 7:00 PM, Saturday, September 28, in the Regency Ballroom.

Registration

The Registration Desk, located outside the Regency Ballroom, 2nd Floor of the Hyatt Hotel, will be open for Delegates at 7:30 AM, Thursday, September 26, and at 6:00 PM, Saturday, September 28. General registration will be held from 7:45 AM until 5:00 PM on Friday and 7:45 AM to 4:00 PM on Saturday, at the General Registration Desk located in the lobby of the Commonwealth Convention Center.



KMA Officers 1995-96



Danny M. Clark, MD
KMA President

On Saturday, September 28, Danny M. Clark, MD, Somerset, will pass the mantle of leadership of the Kentucky Medical Association to William H. Mitchell, MD, Richmond.

Dr Clark, an OB/GYN, has been diligent in his many years of dedicated service to organized medicine. He is a past President of the Pulaski County Medical Society and has been a member of the Kentucky Board of Medical Licensure since 1986. He has served KMA as an Alternate Trustee, Trustee, Vice Speaker and Speaker of the House, President-Elect, and President. He is currently a member of the Scientific Program, Legislative Quick Action, PLI, Public Education, and Maternal and Neonatal Committees, and also serves on the Joint Oversight Group on Health Care Reform.

A native of Paris, Kentucky, Dr Clark received his undergraduate degree from Transylvania University in 1958 and his medical degree in 1962 from the University of Cincinnati.

During the past year, he has provided effective leadership, striving to make decisions that improved the health care of patients and the patient-physician relationship. Dr Danny Clark has been an outstanding spokesperson for the Kentucky Medical Association.



William H. Mitchell, MD
President-Elect

William H. Mitchell, MD, will be installed as President of the Kentucky Medical Association at the President's Luncheon on Saturday, September 28.

A highly respected surgeon practicing in Richmond, Dr Mitchell has been dedicated in his nurturance of organized medicine. During 1992-93, he served simultaneously as President of the Madison County Medical Society, the Kentucky Chapter American College of Surgeons, and the Hiram C. Polk Surgical Society. His service to KMA began in 1981 as 11th District Alternate Trustee, followed by Trustee, Vice-President, and President-Elect. Dr Mitchell currently chairs the Pro Advisory Committee and is a member of the Scientific Program, Physician Workforce, Legislative Quick Action, and PLI Committees, and also serves on the Joint Oversight Group on Health Care Reform.

A native of Salisbury, Maryland, Dr Mitchell received an undergraduate degree from Johns Hopkins University in 1964 and a medical degree from the University of Kentucky in 1970. Following completion of an internship and residency/fellowship at Johns Hopkins Hospital in 1970-72 and a residency in general surgery at the University of Louisville in 1972-75, Dr Mitchell served as a Lieutenant Commander in the US Navy from 1975 to 1977. During that period he served as a ship's surgeon on the USS John F. Kennedy and as attending surgeon at the Portsmouth Naval Hospital in Virginia. In 1977, Dr Mitchell established a private surgical practice in Richmond.

1996 Annual Meeting



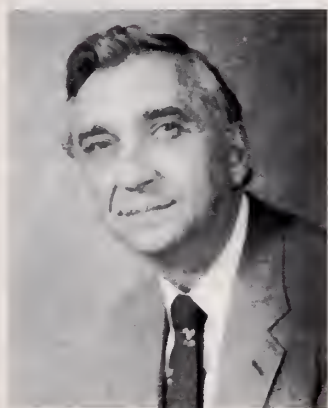
Vice President
Donald R. Stephens, MD
Cynthiana

Dr Stephens, a family physician practicing in Cynthiana, served 23 years as 9th District KMA Delegate, several years as an Alternate Trustee and then Trustee, prior to being named Chairman of the Board of Trustees in 1994 and election to Vice President for 1995-96. He currently serves on the PLI Committee and the Joint Oversight Group on Health Care Reform. A 1960 graduate of the University of Louisville School of Medicine, Dr Stephens is a Fellow of the American Academy of Family Physicians.



Secretary-Treasurer
William P. VonderHaar, MD
Louisville

A family physician, Dr VonderHaar currently serves on the Legislative Quick Action, CME, PLI, National Legislative Activities, and Awards Committees. He is also a member of the Joint Oversight Group on Health Care Reform and is Chair of the KEMPAC Board. Dr VonderHaar was recipient of KMA's Educational Achievement Award in 1988 and was recently named Citizen Doctor of the Year by the Kentucky Academy of Family Physicians.



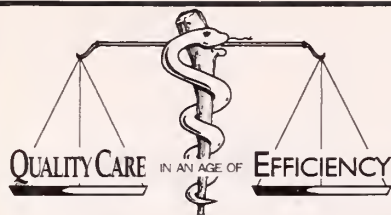
Speaker of the House
C. Kenneth Peters, MD
Louisville

Dr Peters, a family physician, served KMA as Vice Speaker of the House from 1989 until 1994 when he was elected Speaker. He has also served as KEMPAC Chair, on the State Legislative Committee 18 years, and as a KMA Delegate 21 years. A past President of the Jefferson County Medical Society, Dr Peters is a member of the KMA State Legislative Activities Committee, a Charter Fellow of the American Academy of Family Physicians, and a member of the Jefferson County Academy of Family Physicians.



Vice Speaker of the House
John W. McClellan, Jr, MD
Henderson

Dr McClellan, a family physician, served KMA for several years in the House of Delegates and as 2nd District Alternate Trustee from 1982 until 1988 when he was elected Trustee, a position he held until his election as Vice Speaker in 1994. A 1960 graduate of the University of Louisville, Dr McClellan is a past President of the Henderson County Medical Society and is extensively involved in community activities.



KMA Delegates to AMA



Donald C. Barton, MD
Corbin

Dr Barton, a family physician, was elected AMA Delegate in 1984. A past Chair of the KMA Board of Trustees and past KMA President, his extensive service includes KMA Delegate; AMA Alternate Delegate; Vice Chair, Southeastern Delegation, AMA; past President of Whitley County Medical Society; past Chair of KEMPAC Board; and 15th District KMA Trustee for several years. Dr Barton chairs the Committee on National Legislative Activities and serves on the Awards and State Legislative Activities Committees and the Physician Advisory Committee to Health Kentucky. In 1993, Dr Barton received KMA's Distinguished Service Award.



Wally O. Montgomery, MD
Paducah

Dr Montgomery, a general surgeon, was elected AMA Delegate in 1988. He served KMA as Trustee for several years, as Vice-President, President-Elect, President, Alternate AMA Delegate, KEMPAC Chair, and on numerous committees. He chairs the State Legislative, Legislative Quick Action, and PLI Committees and is a member of the Awards Committee. Dr Montgomery is a past KY Governor and past President of the KY Chapter of the American College of Surgeons and a diplomate of the American Board of Surgery. In 1990 he was recipient of KMA's Distinguished Service Award.



Robert R. Goodin, MD
Louisville

Dr Goodin, a cardiologist, was elected AMA Alternate Delegate in 1986 and Delegate in 1990. In 1992, Dr Goodin became a member of the AMA Continuing Medical Education Advisory Committee. He has served KMA as President-Elect and President. He chairs the KMA Physician Organization Study Committee and serves on the CME, Legislative Quick Action, and Physician Workforce Committees and is a member of the Joint Oversight Group on Health Care Reform. Dr Goodin is a Fellow of the American College of Physicians and American College of Cardiology. In 1995, Dr Goodin was elected to the AMA Council on Medical Education.



Ardis D. Hoven, MD
Lexington

Dr Hoven, an infectious disease specialist, was elected AMA Delegate in 1993, following service as an AMA Alternate Delegate from 1989-93. Since 1992 she has been a member of the AMA Advisory Committee on Group Practice. Past service to KMA includes Delegate, Vice President, President-Elect, and President. She currently chairs the Awards Committee and Joint Oversight Group on Health Care Reform and is a member of the Community and Rural Health Committee and Subcommittee on Domestic Violence. Dr Hoven was the 1991 recipient of KMA's Educational Achievement Award.



Donald J. Swikert, MD
Florence

Dr Swikert, a family physician, was elected AMA Delegate in 1994. He served as AMA Alternate Delegate from 1989-94. Dr Swikert was the founding chairman of the Young Physicians Steering Committee, a KMA Alternate Trustee in 1985-88, and currently serves on the Committee to Investigate Changing Trends in Medicine and the Community and Rural Health Committee. Dr Swikert is a past President of the Northern Kentucky Medical Society and the Kentucky Academy of Family Physicians. He currently chairs the Statewide Health Information Network Feasibility Study Committee.

Journal Editors

A. Evan Overstreet, MD, Editor Louisville

Dr Overstreet served on the Editorial Board for more than 6 years before becoming Editor of *The Journal* in September 1977. An internist, Dr Overstreet is a 1955 graduate of the University of Louisville School of Medicine. He is a member of the American Society of Internal Medicine, the American College of Physicians, the Transylvania Medical Society, and former President of the Louisville Society of Internists.

Daniel W. Varga, MD Louisville

Dr Varga joined *The Journal* in 1990 as Scientific Editor. An internist, he is a 1984 graduate of the University of Louisville School of Medicine. He has served as Alternate Delegate and Delegate to the KMA House of Delegates, is currently serving as President of the Jefferson County Medical Society, and is a member of the KMA Ad Hoc Committee to Develop a Comprehensive School Health Education Plan.

Stephen Z. Smith, MD Louisville

Dr Smith has served as Assistant Scientific Editor for *The Journal* since 1977. He also serves as book review author. A dermatologist, Dr Smith is a 1971 graduate of Johns Hopkins University School of Medicine. He is a member of the KMA Claims and Utilization Review Committee and the American Academy of Dermatology.

Milton F. Miller, MD Louisville

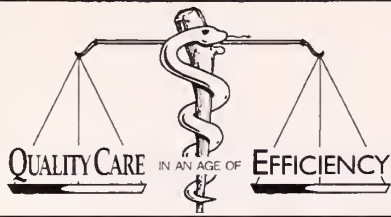
Dr Miller is Associate Clinical Professor of Medicine at the University of Louisville School of Medicine. An internist, Dr Miller has served as Assistant Editor of *The Journal* since 1976, has been active in the Jefferson County Medical Society, and is a former President of the medical staff at Methodist Evangelical Hospital. He is a 1954 graduate of the University of Louisville School of Medicine.

Jaroslav P. Stulc, MD Madisonville

Dr Stulc, a surgeon, joined *The Journal* in 1994 as an Assistant Editor. A 1973 graduate of the University of Iowa College of Medicine, Dr Stulc is affiliated with the Trover Clinic in Madisonville, Kentucky. He is a diplomate of the American Board of Surgery, a fellow of the American College of Surgeons, and an instructor for Advanced Trauma Life Support (ATLS). In addition to his duties at Trover Clinic, Dr Stulc serves as Commander, United States Naval Reserve Medical Corp-Active Duty.

Carolyn D. Burns, MD Louisville

Dr Burns, a pathologist, joined *The Journal* in 1995 as an Assistant Editor. A 1986 graduate of the University of Missouri School of Medicine, Dr Burns is an Associate Clinical Professor in the University of Louisville Department of Pathology and a member of several professional organizations including the American Society of Clinical Pathologists, College of American Pathologists, and the International Academy of Pathology.



KMA District Trustees



Harry W. Carloss, MD
First District



Joseph E. Kutz, MD
Fifth District



Donald R. Neel, MD
Second District



J. Michael Pulliam, MD
Sixth District



Charles R. Dodds, MD
Third District



Ronald E. Waldridge, MD
Seventh District



Eugene H. Shively, MD
Fourth District



Mark F. Pelstring, MD
Eighth District



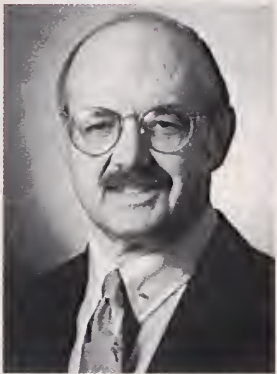
1996 Annual Meeting



J. Gregory Cooper, MD
Ninth District



Kenneth R. Hauswald, MD
Thirteenth District



Russell L. Travis, MD
Tenth District



E. D. Roberts, MD
Fourteenth District



G. Irene Minor, MD
Eleventh District

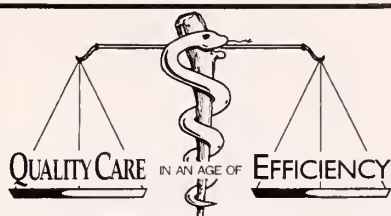


Paul R. Smith, MD
Fifteenth District



Scott B. Scutchfield, MD
Twelfth District





Elections

Nominating Committee to Meet Thursday, September 26

The KMA Nominating Committee will hold an open meeting at the close of the first meeting of the House of Delegates on Thursday, September 26, 1996, in the Regency Ballroom of the Hyatt Regency Hotel, Louisville. Any KMA member may confer with the committee during this meeting.

The report of the Nominating Committee will be posted in the general sessions hall in the Commonwealth Convention Center at the conclusion of the first general session, Friday morning, September 27.

Nominations may be made from the floor during the second meeting of the House of Delegates on Saturday evening, September 28. The House will vote on the nominees at this meeting.

Members of the Nominating Committee are: Susan G. Bornstein, MD, Louisville, Chair; Thomas K. Slabaugh, MD, Lexington; John T. Burch, MD, Bowling Green; Charles G. Nichols, MD, Pikeville; and Charles T. Watson, MD, Ashland.

Nominations should be sent before the Annual Meeting to the KMA Headquarters Office to the attention of the Nominating Committee.

House to Elect New Officers During Annual Meeting

KMA officers for the 1996-97 Association year will be elected by the House of Delegates at the close of its final meeting, Saturday evening, September 28. Officers to be elected from the state-at-large are:

| Office | Term |
|------------------------------------------|---------|
| President-Elect | 1 Year |
| Vice President | 1 Year |
| Secretary-Treasurer | 3 Years |
| *William P. VonderHaar, MD Louisville | |
| Delegates to AMA | 2 Years |
| *Wally O. Montgomery, MD Paducah | |
| *Robert R. Goodin, MD Louisville | |
| *Donald J. Swikert, MD Florence | |
| Alternate Delegates to the AMA | 2 Years |
| *Bob M. DeWeese, MD Louisville | |
| *Preston P. Nunnelley, MD Lexington | |
| *William B. Monnig, MD Edgewood | |
| *Incumbent | |

Election of Trustees and Alternate Trustees

The House of Delegates will elect five District Trustees and five Alternate Trustees at its second regular meeting, Saturday, September 28, 1996. Nominations will be made by the Delegates from the electing Districts at a meeting following the first meeting of the House, on Thursday, September 26.

The Nominating Committee will report at the close of the first scientific session on Friday, September 27. Further nominations may be made from the floor at the final meeting of the House on Saturday evening, September 28. All nominations are considered and acted upon by the Delegates at this final meeting.

Districts electing Trustees for 3-year terms are: 5th District (incumbent, Joseph E. Kutz, MD, Louisville); 6th District (incumbent, J. Michael Pulliam, MD, Franklin); 8th District (incumbent, Mark F. Pelstring, MD, Covington); 11th District (incumbent, G. Irene Minor, MD, Berea); and 15th District (incumbent, Paul R. Smith, MD, London). Trustees in the 6th and 11th Districts are eligible for reelection; while those in the 5th, 8th, and 15th have served two, consecutive terms and are not eligible for reelection.

Districts electing Alternate Trustees are the same as those electing Trustees. Incumbents are: 5th District, Daniel W. Varga, MD, Louisville; 6th District, John T. Burch, II, MD, Bowling Green; 8th District, John D. Ammon, MD, Florence; 11th District, Richard A. Stone, MD, Richmond; and 15th District, Roger A. Acosta, MD, Barbourville.

Alternate Trustees in the 5th, 6th, and 11th Districts are eligible for reelection; while those in the 8th and 15th Districts have both served two, consecutive terms and are not eligible for reelection.

Reference Committee Activity

Speakers C. Kenneth Peters, MD, Louisville, and John W. McClellan, Jr, MD, Henderson, will assign all officers' and committees' reports and resolutions to one of five reference committees at the first meeting of the KMA House of Delegates at 9:00 AM, Thursday, September 26. A brief session for reference committee chairs will be held at 12:00 NOON, Thursday, in the Derby Room, located on the second floor of the Hyatt Hotel. Any KMA member wishing to testify on any resolution or report is urged to be present for the reference committee meetings which will be held at 1:00 PM, Thursday, September 26, in the first floor meeting

rooms in the Hyatt Hotel. These open sessions will last at least one hour in order for all who wish to speak to be heard. Following the open hearings, the committees will go into executive session to study the reports, review the testimony, and write their reports to the House.

The committees' recommendations will be presented at the final meeting of the House, Saturday evening, September 28, in the Regency Ballroom, Hyatt Hotel.

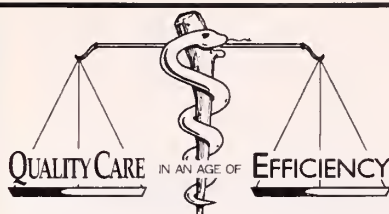
Appointments for reference committees, the Credentials Committee, and Tellers are now being finalized by the Speakers. If your society has not yet

submitted the name of your delegate(s) to the Headquarters Office, you should do so immediately, as only those names recorded in the office can be considered for appointment to one of the reference committees and be listed as official county society representatives.

A complete listing of members who will be serving on the five reference committees and the location of the reference committee meetings will be published in the September issue of the *KMA Journal*. Anyone desiring names of reference committee members before the September issue is published should contact the Headquarters Office.

MAKE YOUR RESERVATIONS NOW!

It is important that you begin to make your room reservations as soon as possible for the KMA Annual Meeting, September 25-28. The Hyatt Regency Louisville will be the Headquarters Hotel (Phone 502/587-3434). In making your reservations, remember the first House of Delegates meeting will be Thursday, September 26. Be sure and identify yourself as a KMA meeting attendee to receive the special convention rate---Single-\$76/Double-\$86.



KMA Delegates

FIRST DISTRICT

Ballard

Martha C. Robinson, MD, Barlow

Calloway

Robert C. Hughes, MD, Murray

Rob T. Williams, MD, Murray

Carlisle

Fulton

Graves

Charles E. Bea, MD, Mayfield

Patricia S. Elliott, MD, Mayfield

Hickman

Bruce C. Smith, MD, Clinton

Livingston

Stephen Burkhart, MD, Salem

Marshall

McCracken

John E. Grubbs, MD, Paducah

Kurt Klauburg, DO, Paducah

Peter E. Locken, MD, Paducah

Bradley T. Rankin, MD, Paducah

Norma T. Rankin, MD, Paducah

Charles B. Ross, MD, Paducah

Carolyn S. Watson, MD, Paducah

SECOND DISTRICT

Davies

Christopher J. Havelda, MD, Owensboro

Robert H. Schell, MD, Owensboro

JD Loucks, MD, Owensboro

William Madauss, MD, Owensboro

R. Wathen Medley, Jr, MD, Owensboro

William Milnor, MD, Owensboro

Linda Mumford, MD, Owensboro

Hancock

Henderson

John S. Cave, MD, Henderson

Marcia L. Cave, MD, Henderson

Marshall G. Howell III, MD, Henderson

McLean

Ohio

Eric A. Norsworthy, MD, Hartford

Union

Webster

THIRD DISTRICT

Caldwell

Christian

Crittenden

Gary V. James, MD, Marion

Hopkins

Iyad A. Al-Jabi, MD, Madisonville

Wallace R. Alexander, MD, Madisonville

James M. Bowles, MD, Madisonville

Uday V. Dave, MD, Madisonville

Lyon

Muhlenberg

James S. Brashear, MD, Central City

Todd

Trigg

FOURTH DISTRICT

Breckinridge

James G. Sills, MD, Hardinsburg

Bullitt

Grayson

Art McLaughlin, MD, Leitchfield

Green

William L. Shuffett, MD, Greensburg

Hardin

Lucian Moreman, MD, Elizabethtown

Jeffrey Richardson, MD, Elizabethtown

David Zoeller, MD, Elizabethtown

Hart

James P. Crews, MD, Cave City

Larue

Meade

Raymond L. Mathis, DO, Brandenburg

Marion

Richard L. Litt, MD, Lebanon

Nelson

Taylor

Eugene H. Shively, MD, Campbellsville

Washington

Brian F. Wells, MD, Springfield

FIFTH DISTRICT

Jefferson

Edward C. Adler, MD, Louisville

Stephanie S. Altobellis, MD, Louisville

Kenneth C. Anderson, MD, Louisville

George R. Aronoff, MD, Louisville

Joseph C. Banis, Jr, MD, Louisville

Susan M. Berberich, MD, Prospect

Karen Kaye Bloom, MD, Louisville

C. Matthew Brown, MD, Louisville

Gregory L. Brown, MD, Louisville

William C. Buschemeyer, Jr, MD, Louisville

Donn R. Chatham, MD, Louisville

William G. Cheadle, MD, Louisville

J. William Comer, MD, Louisville

Warren M. Cox IV, MD, Louisville

Frederick Cressman, Jr, MD, Louisville

John H. Doyle, MD, Louisville

Michael J. Edwards, MD, Louisville

Rudy J. Ellis, Jr, MD, Louisville

Samuel G. Eubanks, Jr, MD, Louisville

Marjorie R. Fitzgerald, MD, Louisville

Gary L. Fuchs, MD, Louisville

Katherine P. Garrison, MD, Louisville

Carolyn B. Gleason, MD, Louisville

Leonard A. Goddy, MD, Louisville

Lawrence G. Goldberg, MD, Louisville

Richard A. Gould, MD, Louisville

Manuel Grimaldi, MD, Louisville

Kathleen C. Harter, MD, Louisville

William P. Hoagland, MD, Louisville

Jayne L. Hollander, MD, Louisville

Anna K. Huang, MD, Louisville

John G. Hubbard, MD, Louisville

Walter I. Hume, Jr, MD, Louisville

Barbara Sue Isaacs, MD, Louisville

Ellen M. Joyce, MD, Louisville

Margie Rae Joyce, MD, Louisville

Stephen S. Kirzinger, MD, Louisville

A. O'tayo Lalude, MD, Louisville

Gerald M. Larson, MD, Louisville

Julie S. Lee, MD, Louisville

Michael T. Macfarlane, MD, Louisville

Mario Maya, MD, Louisville

Michael W. McCall, MD, Louisville

Martha T. McCoy, MD, Louisville

James E. McKiernan, Jr, MD, Louisville

Arthur J. McLaughlin II, MD, Louisville

Cathleen J. Morris, MD, Louisville

Ralph C. Morris, MD, Louisville

Richard R. Morris, MD, Louisville

Catherine Newton, MD, Louisville

Thomas G. O'Daniel, Jr, MD, Louisville

Vaughn W. Payne, MD, Louisville

Robert L. Pence, MD, Louisville

Hiram C. Polk, Jr, MD, Louisville

Ben A. Reid, Jr, MD, Louisville

Steven J. Reiss, MD, Louisville

William M. Renda, MD, Louisville

Barton Reutlinger, MD, Louisville

Alan I. Roth, MD, Louisville

Kailash C. Sabharwal, MD, Louisville

Joseph S. Sanfilippo, MD, Louisville

George R. Schrodt, Jr, MD, Louisville

Lynn T. Simon, MD, Louisville

Alfred L. Thompson, MD, Louisville

Regulo J. Tobias, MD, Louisville

Brenda I. Townes, MD, Louisville

Gary C. Vitale, MD, Louisville

Henry J. Walter, MD, Louisville

Barbara Weakley-Jones, MD, Louisville

Morris M. Weiss, Jr, MD, Louisville

John J. Whitt, MD, Louisville

James Anthony Wright, MD, Louisville

Janet Wygal, MD, Louisville

C. Milton Young, III, MD, Louisville

George H. Zenger, MD, Louisville

SIXTH DISTRICT

Adair

Gary L. Partin, MD, Columbia

Allen

Barren

Warren J. Eisenstein, MD, Glasgow

Melissa Walton-Shirley, MD, Glasgow

Butler

Richard T. Wan, MD, Morgantown

Cumberland

Joseph D. Skipworth, MD, Burkesville

Edmonson

Omkar N. Bhatt, MD, Brownsville

Logan

Metcalf

Monroe

James E. Carter, MD, Tompkinsville

Simpson

Michael Pulliam, MD, Franklin

Warren

James F. Beattie, Jr, MD, Bowling Green

Mark E. Bigler, MD, Bowling Green

John T. Burch, MD, Bowling Green

Robert J. Emslie, MD, Bowling Green

Rebecca D. Shadowen, MD, Bowling Green

SEVENTH DISTRICT

Anderson

Kenneth E. Hines, MD, Lawrenceburg

Carroll

Cecil D. Martin, MD, Carrollton

Franklin

Joseph J. Dobner, MD, Frankfort

Arba L. Kenner, MD, Frankfort

John M. Patterson, MD, Frankfort

1996 Annual Meeting

Gallatin

Benjamin Kutnicki, MD, Warsaw

Grant

Henry

Oldham

Harold F. Funke, MD, Pee wee Valley

Owen

Jafar Mahmood, MD, Owenton

Shelby

James R. Smith, MD, Shelbyville

Ronald E. Waldrige, MD, Shelbyville

Spencer

Thomas C. Crain, MD, Taylorsville

Trimble

Carl Cooper, Jr, MD, Bedford

EIGHTH DISTRICT

Boone

Robert L. Baker, Jr, MD, Crescent Springs

Michael L. Robinson, MD, Covington

Campbell

James L. Evans, III, MD, Fort Thomas

Steven L. Steinkamp, MD, Edgewood

Steven L. Willett, MD, Fort Thomas

Steven M. Woodruff, MD, Florence

Kenton

Gordon W. Air, MD, Crestview Hills

Elbert D. Baldrige, Jr, MD, Covington

Thomas E. Bunnell, MD, Erlanger

Mark A. Cepela, MD, Edgewood

Michael R. Kirkwood, MD, Covington

Joseph C. Martin, MD, Erlanger

Ross McHenry, MD, Covington

Theodore H. Miller, MD, Edgewood

Richard E. Park, MD, Covington

B. Robert Schwartz, MD, Edgewood

NINTH DISTRICT

Bath

Bourbon

Bracken

Fleming

Glenn R. Womack, MD, Flemingsburg

Harrison

Donald R. Stephens, MD, Cynthiana

Mason

David Doty, DO, Maysville

Leroy Shouse, MD, Maysville

Nicholas

Jose T. Lorenzo, MD, Carlisle

Pendleton

Robert L. McKenney, MD, Falmouth

Robertson

Scott

John M. Bennett, MD, Georgetown

TENTH DISTRICT

Fayette

James W. Baker, MD, Lexington

James R. Bean, MD, Lexington

David J. Bensema, MD, Lexington

John V. Borders, MD, Lexington

Kathleen J. Bos, MD, Lexington

John W. Collins, MD, Lexington

Elvis S. Donaldson, Jr, MD, Lexington

Richard D. Floyd, IV, MD, Lexington

John M. Fox, MD, Lexington

Bill H. Harris, MD, Lexington

Raleigh O. Jones, MD, Nicholasville

Magdalene B. Karon, MD, Lexington

Dennis B. Kelly, MD, Lexington

Daniel E. Kenady, Sr, MD, Lexington

John M. Moore, MD, Lexington

William D. Newton, MD, Lexington

William N. Offutt, IV, MD, Lexington

Gregory V. Osetinsky, MD, Lexington

Charles L. Papp, MD, Nicholasville

Barbara A. Phillips, MD, Lexington

John W. Poundstone, MD, Lexington

Glenn R. Shearer, MD, Lexington

Thomas K. Slabaugh, MD, Lexington

David B. Stevens, MD, Lexington

John D. Stewart, MD, Lexington

John Robert White, MD, Lexington

Emery A. Wilson, MD, Lexington

Jessamine

Woodford

Norman S. Fisher, MD, Midway

ELEVENTH DISTRICT

Clark

Daniel Alan Ewen, MD, Winchester

Estill

John A. Patterson, MD, Irvine

Lee

James B. Noble, MD, Beattyville

Jackson

Madison

Jerome Krumpelman, Jr, MD, Richmond

Gladys Irene Minor, MD, Berea

Richard A. Stone, MD, Richmond

Montgomery

Lon E. Roberts, Jr, MD, Mount Sterling

Menifee

Owsley

Powell

Charles G. Noss, MD, Stanton

Wolfe

Paul Maddox, MD, Compton

TWELFTH DISTRICT

Boyle

Brian E. Ellis, MD, Danville

David C. Liebschutz, MD, Danville

Arthur K. Rivard, MD, Danville

Casey

Clinton

Michael Lee Cummings, MD, Albany

Garrard

Paul J. Sides, MD, Lancaster

Lincoln

McCreary

Mercer

Pulaski

Steven M. DeMunbrun, MD, Somerset

Christopher J. Frost, MD, Somerset

Billy Joe Parson, MD, Somerset

Rockcastle

Russell

H. Michael Oghia, MD, Russell Springs

Wayne

Edward Joseph, MD, Monticello

THIRTEENTH DISTRICT

Boyd

Paul W. Craig, II, MD, Ashland

Maurice J. Oakley, MD, Ashland

Roger Potter, MD, Ashland

Susan Prasher, MD, Ashland

Charles Watson, MD, Ashland

Carter

Elliott

Greenup

John O. Jones, MD, Flatwoods

Lawrence

Lewis

Morgan

George R. Bellamy, MD, West Liberty

Rowan

Alan T. Mong, MD, Morehead

FOURTEENTH DISTRICT

Breathitt

Floyd

Nicholas R. Jurich, MD, Prestonsburg

Gangadhar L. Maddiwar, MD, Martin

Letcher

Johnson

Franklin K. Belhasen, MD, Paintsville

Knot

Magoffin

Martin

Perry

Pike

Lela C. Maynard, MD, Pikeville

Baretta Casey, MD, Pikeville

FIFTEENTH DISTRICT

Bell

Clay

Ira F. Wheeler, MD, Manchester

Harlan

Sharon M. Colton, MD, Evarts

Abdulkader Dahhan, MD, Harlan

Knox

William S. Black, MD, Barbourville

Laurel

William D. Pratt, MD, London

Leslie

Whitley

P. Bruce Barton, MD, Corbin

KMA Student Section

UL — Amy Waltrip, Louisville

UK — Michael Todd Newman, Lexington

KMA Resident Physicians Section

D. Shawn Parker, MD, Louisville

KMA Organized Medical Staff Section

J. D. O'Brien, MD, Louisville

**Kentucky Medical Insurance Company
1996 Risk Management Seminar
For Medical Office/Clinic Staff**

Kentucky Medical's seminar for Medical Office and Clinic Staff is designed to improve office procedures and systems in an effort to minimize the malpractice risk in a medical office. The 1996 seminar focuses on the medical office/clinic staff's responsibilities regarding the medical record. The fast-paced program is titled, *"The Best Line of Defense"*. This seminar is recommended for *all* medical office/clinic staff personnel. Early registration is encouraged. The cost of the seminar is:

\$25.00 per staff member of KMIC insureds
\$50.00 per staff member for non-insureds

The seminar is scheduled from 9:00 to 11:00 AM on Friday, September 27, 1996, at the Hyatt Regency Louisville. If you would like to request a registration form, please call Cindy Kortz or Stephanie Singleton at Kentucky Medical Insurance Company either toll free at 800/467-1858, or in Louisville, 502/339-5771. *All medical office/clinic staff personnel are urged to attend.*

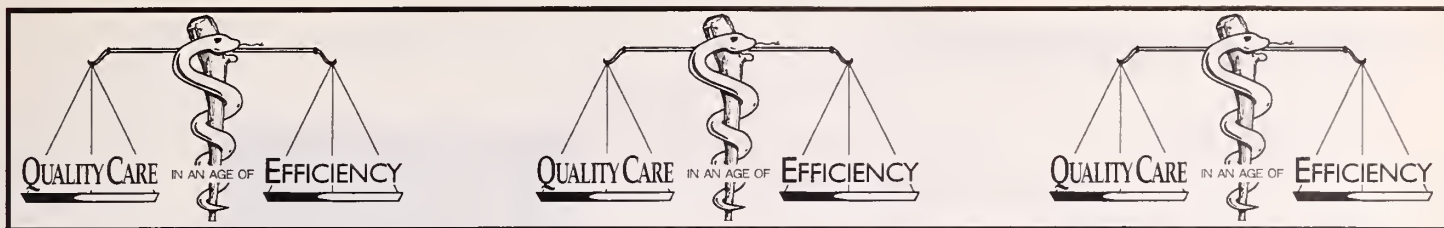
**Kentucky Medical Insurance Company
1996 Risk Management Seminar For Physicians**

Kentucky Medical Insurance Company will be presenting a two-hour Risk Management Seminar on the topics of managed care and the early diagnosis of cancer, during the KMA Annual Meeting. The seminar will be held Wednesday, September 25, 1996, at the Hyatt Regency Louisville. Lunch will be provided from 12:00 noon until 12:30 pm. The seminar will begin promptly at 12:30 pm and conclude at 2:30 pm. The cost of the seminar is \$50.00 and is open to all physicians.

The Kentucky Medical Insurance Company is accredited by the Kentucky Medical Association to sponsor continuing medical education for physicians. Kentucky Medical Insurance Company designates this activity for two credit hours in Category I of the Physicians Recognition Award of the American Medical Association.

Physicians insured with Kentucky Medical Insurance Company will receive a 5% premium credit on their next policy renewal. *Participants must attend the entire seminar program and complete required forms to be eligible for premium credit and CME credit.*

If you would like to request a registration form, please call Cindy Kortz or Stephanie Singleton at Kentucky Medical Insurance Company, toll free at 800/467-1858 or in Louisville at 502/339-5700.



Abridged Schedule of Annual Meeting Events

CC = Commonwealth Convention Center
HH = Hyatt Regency Hotel

Wednesday, September 25

- 9:00 AM KMA Executive Committee Meeting
12:30 PM KMA Board of Trustees Meeting & Lunch

Derby Room-HH
Regency Ballroom South-HH

Thursday, September 26

- 7:30 AM Registration for House of Delegates
7:30 AM Continental Breakfast for House of Delegates
hosted by JCMS
9:00 AM First Meeting, KMA House of Delegates
11:30 AM Trustee Districts Nominating Committees/
KMA Nominating Committee
11:45 AM Rural Caucus/Luncheon
12:00 NOON Reference Committee Chair Luncheon
1:00 PM Reference Committee Meetings
6:00 PM KEMPAC Reception & Dinner

Outside Regency Ballroom-HH
Regency Ballroom Foyer-HH

Regency Ballroom North & Center-HH
Regency Ballroom North & Center-HH

Keeneland Suite-HH
Derby Room-HH
Various Meeting Rooms-HH
Regency Ballroom-HH

Friday, September 27

- 7:00 AM KEMPAC Board Breakfast Meeting
7:00-9:00 AM Reference Committee Report Signing
7:30-11:00 AM Alliance Registration
7:45 AM Registration
8:15-9:00 AM Free Coffee & Danish
8:30 AM Opening Ceremonies, First Scientific Session
8:30-10:50 AM Alliance Combined Committee Meetings
11:00-2:00 PM Alliance Fall Board Meeting/Luncheon
12:00 NOON Young Physicians Luncheon
12:00 NOON Executive Committee & Reference Committee
Chair Luncheon Meeting
1:00 PM MSS/RPS Annual Meeting
1:30 PM Specialty Group Sessions . . . 11 Specialty Groups
will meet simultaneously at this time.

Keeneland Suite-HH
Churchill Downs-HH
Outside Regency Ballroom-HH
Registration Area-CC
Exhibit Hall-CC
General Sessions Area-CC
Regency Ballroom South A-HH
Regency Ballroom South B-HH
Keeneland Suite-HH
Kentucky Suite-HH

Meeting Room 104-CC
Various Meeting Rooms-CC
(Programs begin on page 000)

Saturday, September 28

- 7:45 AM Registration
8:15-9:00 AM Free Coffee & Danish
8:30 AM Second Scientific Session
11:50 AM President's Installation/Awards Luncheon
2:15 PM Specialty Group Sessions . . . 12 Specialty Groups
will meet simultaneously at this time.
3:00 PM KMA Board of Trustees Meeting
5:00 PM Rural Caucus Meeting/Dinner
7:00 PM Second Meeting, KMA House of Delegates

Registration Area-CC
Exhibit Hall-CC
General Sessions Area-CC
Regency Ballroom North & Center-HH
Various Meeting Rooms-CC
(Programs begin on page 000)
Regency South-HH
Keeneland Suite-HH
Regency Ballroom North & Center-HH

Sunday, September 29

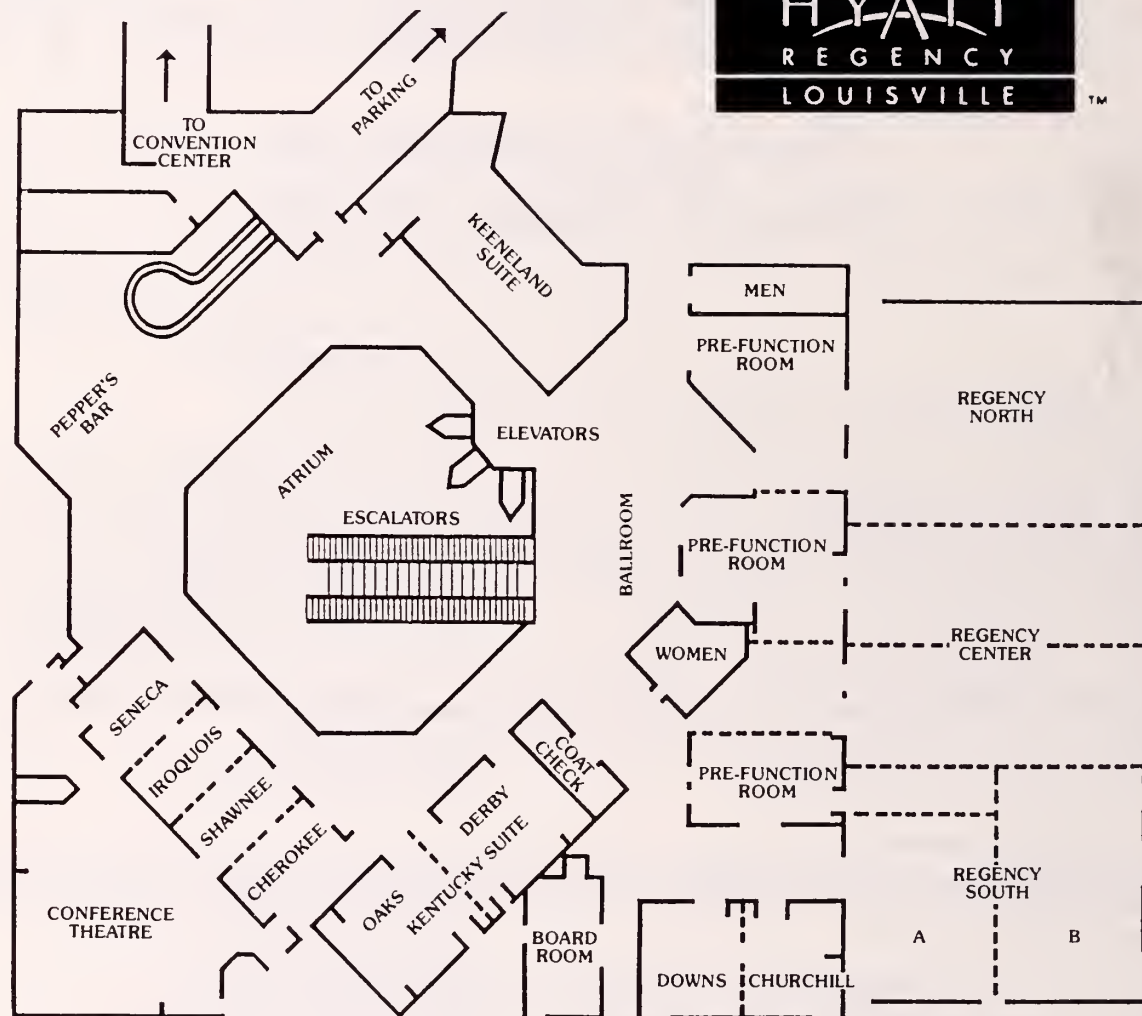
- 7:30 AM KMA Board of Trustees Breakfast Meeting

Regency South A-HH

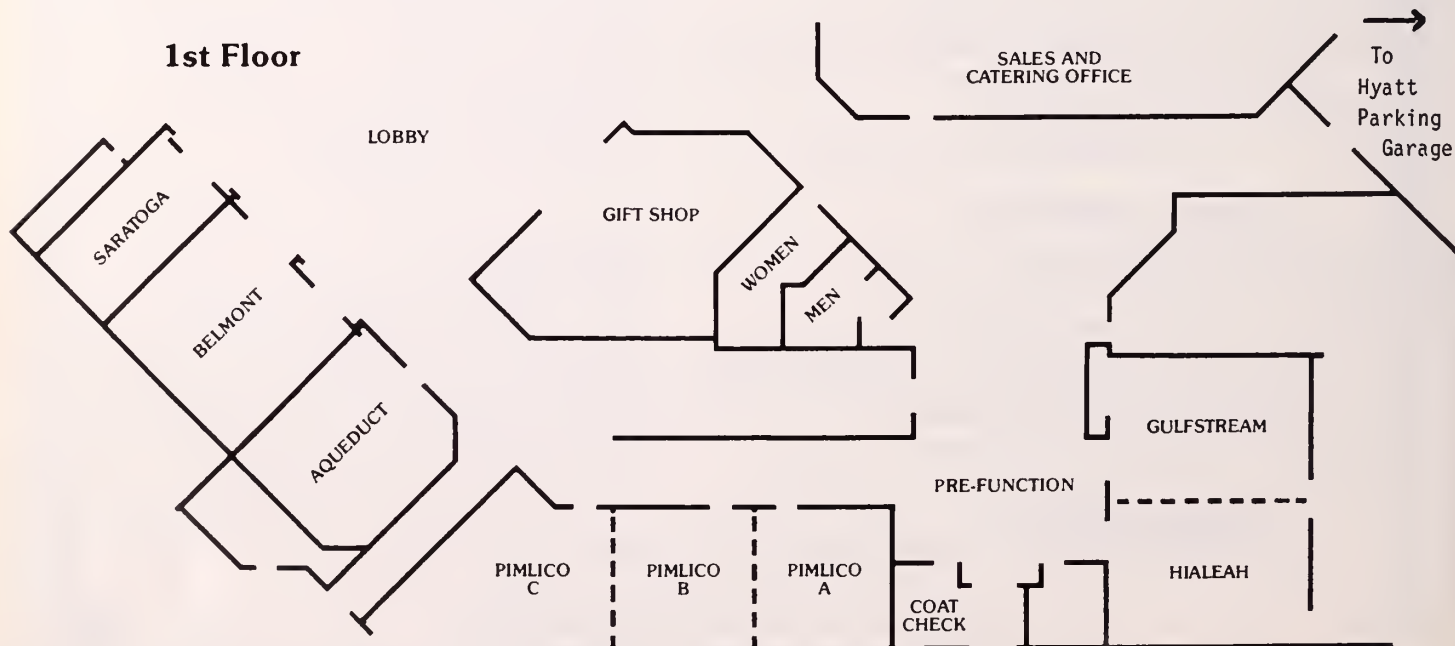
*A 30-minute intermission has been scheduled during each Scientific Session
and Specialty Group Session for visiting Exhibits.*

HOTEL FUNCTION SPACE

2nd Floor



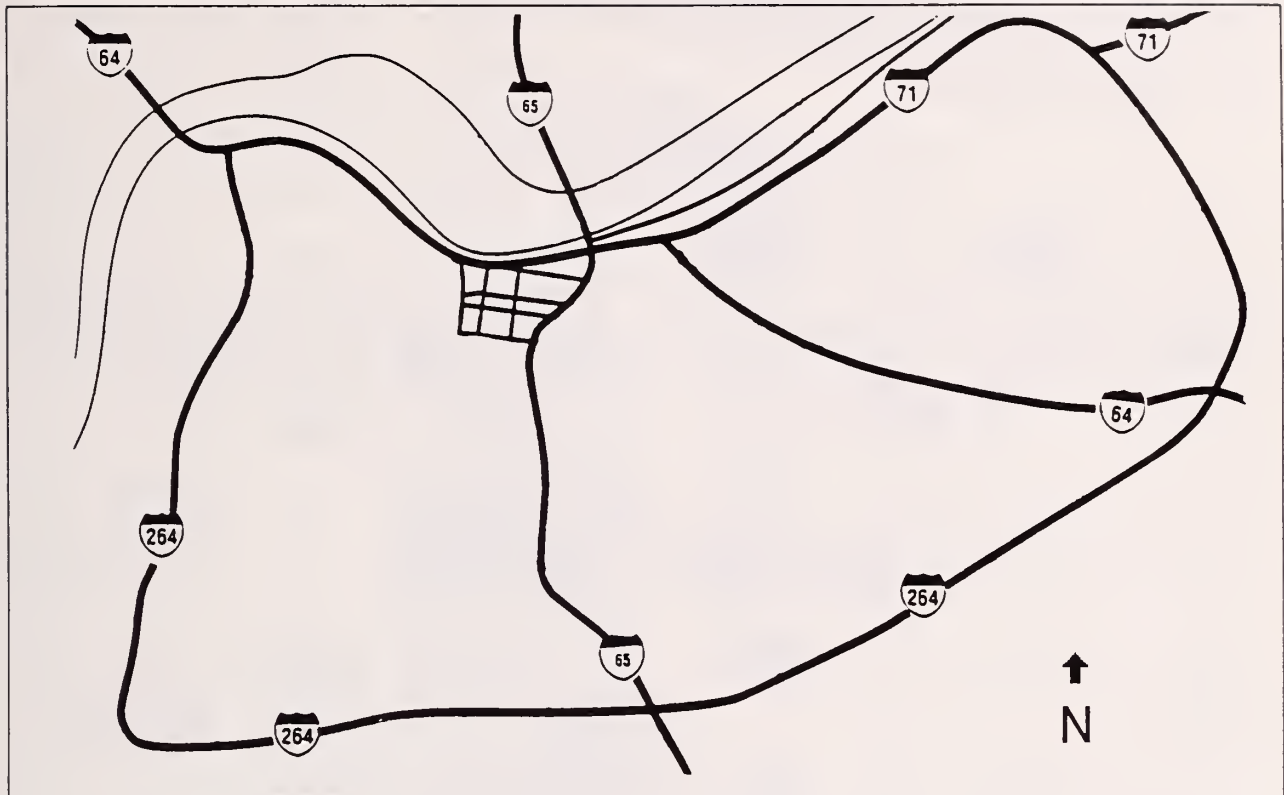
1st Floor



TEAR OUT MAPS

of Major Routes and Convenient Parking Locations in Downtown Louisville

TO REACH HYATT REGENCY/ COMMONWEALTH CONVENTION CENTER



MAP INSET OF DOWNTOWN LOUISVILLE


From I-64/I-71 Westbound:
Take 3rd St. exit, go south
on 3rd, turn right on Jefferson.


From I-64 Eastbound:
Take 9th St. exit, go south
on 9th, turn left on Market.

From I-65 Northbound:
Take Muhammad Ali Blvd.
exit, go west on Muhammad
Ali, turn right at 2nd St., turn
left at Jefferson.

| I-64 | | | | | | | | | |
|----------|----------|----------|----------|------------------------|--|----------|----------|----------|----------|
| | | | | ↔ Main St. ↔ | | | | | |
| 9th ↓ | 8th ↓ | 7th ↓ | | Market St. → | | 4th ↓ | 3rd ↓ | 2nd ↓ | 1st ↓ |
| | | | | ↔ Jefferson St. ↔ | | | CCC | | |
| | | | | ↔ Liberty St. ↔ | | | Hyatt | | |
| | | | | ↔ Muhammad Ali Blvd. ↔ | | | | | |
| | | | | ↔ Chestnut St. ↔ | | | | | |
| | | | | ↔ Broadway ↔ | | | | | |
| | | | 6th ↓ | 5th ↓ | | | | | |
| | | | | | | | | | I-65 |

DETAILED PARKING MAP ➡

 Trolley Stops

 Public Parking

Louisville Falls Fountain

I-64 (to I-71)

River Road

River Road

1-64

Riverfront Plaza/
Salvedere

Kentucky Center
for the Arts

Louisville Fort Nelson
Science Park
Center

Gelt House

[← Main](#)

Bunbury
Theatre

**Actors
Theatre**

- Market ▶

Commonwealth
Convention
Center

Convention
Center
Expansion Area

Convention
Center
Expansion Area
opening 1997

second

First

Jefferson

Jefferson
Square

Hyatt
Regency

Liberty >

Louisville
Gazette

Muhammad
Museum

Louisville
Gardens

Arm

Four Squ

◀ Muhammad
Seibt



Guthrie
Green

Martin Luther
King Jr. Park

Ch

The Brennan
House

The Palace
Theatre

Theater
Square

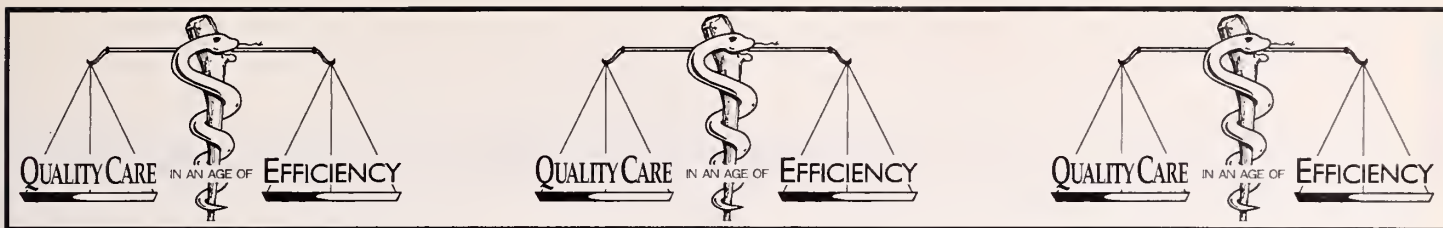
The Brown
Hotel Mecauley
Theatre

Broadway

Louisville
Free Public

Louisville
Automobile

York



Annual Meeting Special Features

1996 Annual Meeting Honors Past President James W. Kincaid, MD

The 1996 Annual Meeting of the Kentucky Medical Association will be officially titled "The James W. Kincaid Meeting" in remembrance of the 1916 President of the Association. The tradition of honoring a past president of KMA and other distinguished physicians originated with the 1935 Annual Meeting. Eugene H. Conner, MD, Louisville, KMA Historian, has written a biography on Dr Kincaid that begins on page 344.

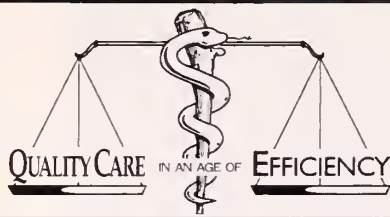
Scientific Sessions are scheduled for Friday and Saturday, September 27 and 28, at the Commonwealth Convention Center in Louisville. The theme for the 1996 scientific session is "Quality Care In An Age of Efficiency." Both the presentations and discussion periods will contribute to the continuing medical education of Kentucky's physicians.

Twenty-four Specialty Groups will hold meetings on September 27 and 28 beginning at 1:30 PM on Friday and 2:15 PM on Saturday. Individual programs of specialty societies and meeting locations are listed in this issue. All general sessions will be held in the mornings. Specialty groups will meet both days with no general sessions scheduled during these specialty group meetings. All KMA members are invited to attend any specialty meetings.

Scientific and Technical Exhibits will display new medical products, services, and techniques in the Exhibit Hall, located in the Commonwealth Convention Center during the 1996 Annual Meeting. Members and guests are urged to take the opportunity to view products of interest at the 30-minute intermissions scheduled during each general and specialty session.

The KMA House of Delegates will meet twice during the Annual Meeting. The first meeting of the House will be held at 9:00 AM, Thursday, September 26, in the Regency Ballroom located in the Hyatt Hotel. The final meeting will be held Saturday, September 28, at 7:00 PM, in the Regency Ballroom. Officers for the 1996-97 Associational year will be elected at the second meeting.

The President's Installation & Awards Luncheon will be held on Saturday, September 28, in the Regency Ballroom located in the Hyatt Hotel. The luncheon will include the presentation of KMA awards and the installation of the 1996-97 President, William H. Mitchell, MD, Richmond.



Introducing the Guest Speakers

OBSTETRICS/GYNECOLOGY



Eli Y. Adashi, MD
Baltimore, MD

Professor and Director, Department of OB/GYN, University of Maryland School of Medicine. MD, 1972, Sackler Medical School, Israel. Member, American College of Obstetrics/Gynecology.

PUBLIC HEALTH



Reginald Finger, MD
Frankfort, KY

Director, Division of Epidemiology, Dept for Health Services; Asst Professor, University of Kentucky Preventive Medicine. MD, 1981, U of Washington, Seattle. Member, Council of State and Territorial Epidemiologists.

COLLEGE OF PHYSICIANS



Marshall S. Stanton, MD
Rochester, MN

Associate Professor of Medicine, Mayo Graduate School of Medicine; Consultant, Division of Cardiovascular Medicine, Mayo Clinic. MD, 1982, Medical College of Virginia. Fellow, American College of Cardiology.

INTERNAL MEDICINE



Jose Salvador Martinez, MD
Lakeland, FL

Staff Internist, Watson Clinic, Lakeland; Lecturer, Florida Southern College. MD, 1980, Emory University School of Medicine. Fellow, American College of Physicians.

ORTHOPAEDICS



Joseph C. McCarthy, Jr, MD
Boston, MA

Associate Clinical Professor Orthopedic Surgery, Tufts University School of Medicine, Boston. MD, 1975, Georgetown U. Fellow, American Academy of Orthopaedic Surgeons, American College of Surgeons, International College of Surgeons.

PEDIATRICS

Gerard Rabalais, MD
Louisville, KY

Co-Director, Pediatric Virology Laboratory, Department of Pediatrics, University of Louisville. MD, 1981, Louisiana State University School of Medicine. Fellow, American Academy of Pediatrics; Post President, Louisville Pediatric Society.

GERIATRICS



Matthew F. Emons, MD
Louisville, KY

Medical Director of Utilization and Quality, Humana Health Care Plans, Louisville. MD, 1983, University of Illinois College of Medicine. Diplomate, American Board of Internal Medicine.

DERMATOLOGY



Marilynne McKay, MD
Atlanta, GA

Professor of Dermatology and Gynecology/Obstetrics, Emory University, Atlanta. MD, 1976, University of New Mexico. Fellow, American Academy of Dermatology.

FAMILY PHYSICIANS



Peter Stringham, MD
Brookline, MA

Associate Professor of Clinical Pediatrics, Boston University; East Boston Neighborhood Health Center. MD, 1968, Columbia College of Physicians and Surgeons. Member, American Academy of Family Practice.

PATHOLOGY



Peter B. Baker, MD
Columbus, OH

Director, Division of Autopsy Pathology and Electron Microscopy, and Academic Program Director for Med II, Ohio State University. MD, 1978, Ohio State University. Fellow, College of American Pathologists.

UROLOGY



Tam F. Lue, MD
San Francisco, CA

Professor of Urology, University of California-San Francisco. MD, 1972, University of Taiwan. Member, American Urology Association.

ALLERGY/CLINICAL IMMUNOLOGY



Donald Y. M. Lueng, MD
Englewood, CO

Senior Staff Physician and Head, Division of Pediatric Allergy-Immunology, National Jewish Center for Immunology and Respiratory Medicine; Professor, Dept of Pediatrics, U of Colorado Health Sciences Center, Denver. MD, 1977, U of Chicago. Fellow, AAAI.

1996 Annual Meeting

COLLEGE OF SURGEONS



Hiram C. Polk, Jr, MD
Louisville, KY

Ben A. Reid, Sr Professor and Chairman, Department of Surgery, University of Louisville. MD, 1960, Harvard University. Post President, Southern Surgical Assn; Southeastern Surgical Congress; Kentucky Surgical Society. Fellow, American College of Surgeons. Honorary Fellow, Royal College of Surgeons of Edinburgh.

ANESTHESIOLOGY



Brett B. Gutsche, MD
Paoli, PA

Staff Anesthesiologist, Hospital of the University of Pennsylvania; Professor of Anesthesiology and Professor of OB/GYN, University of Pennsylvania School of Medicine. MD, 1961, University of Rochester. Post President, Society of Obstetrical Anesthesia & Perinatology.

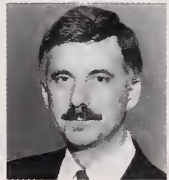
OCCUPATIONAL MEDICINE



Kent W. Peterson, MD
Charlottesville, VA

President, Occupational Health Strategies, Inc., Charlottesville; Clinical Professor, Environmental Medicine, New York U. MD, 1968, U Pennsylvania. President-Elect, American College of Occupational/Environmental Medicine. Fellow, American College of Occupational/Environmental Medicine and American College of Preventive Medicine.

GASTROENTEROLOGY



Gregory Van Stiegmann, MD
Denver, CO

Chief, Division of Gastrointestinal, Tumor and Endocrine Surgery; Associate Professor of Surgery; Chief, Surgical Endoscopy, U of Colorado School of Medicine. MD, 1975, Abraham Lincoln School of Medicine, Chicago. Founding Member, American Trauma Society.

EMERGENCY MEDICINE

David Rasumoff, MD
La Crescenta, CA

Clinical Assistant, Professor of Emergency Medicine, LA County-USC Medical Center; Medical Officer, LA Sheriff's Department, 16 years. MD, 1969, U of Colorado. Member, Department of Defense Program, CONTOMS, Uniformed Services, U for the Health Sciences, Bethesda.

NEUROSURGERY



Ossama Al-Mefty, MD
Little Rock, AR

Professor and Chair, Dept of Neurosurgery, U of Arkansas for Medical Sciences. MD, 1972, Damascus University Medical School, Damascus, Syria. Fellow, American College of Surgeons; President-Elect, North American Skull Base Society; Member, World Federation of Neurosurgical Societies Skull Base Committee.

PLASTIC/RECONSTRUCTIVE SURGERY



James W. May, Jr, MD
Boston, MA

Director, Plastic Surgery, Massachusetts General Hospital; Professor of Surgery, Harvard Medical School, Boston. MD, 1969, Northwestern University Medical School. Past President, Northeastern Society of Plastic Surgeons, American Association for Hand Surgery, and past Chair, American Board of Plastic Surgery.

PSYCHIATRY



Harold I. Eist, MD
Bethesda, MD

Private Practice in Psychiatry; Medical Director, Montgomery Child and Family Health Services, Inc; Faculty, Howard University and Washington School of Psychiatry. MD, 1961, University of Alberta Medical School, Canada. President, American Psychiatric Association and American Association of Private Practice Psychiatrists.

EYE PHYSICIANS/SURGEONS



Stephen A. Obstbaum, MD
Leonia, NJ

Professor of Clinical Ophthalmology, New York University Medical School; Director, Lenox Hill Hospital Dept of Ophthalmology, NY. MD, 1967, New York Medical College. President-Elect, American Academy of Ophthalmology.

PHYSICAL MEDICINE & REHABILITATION



Gerald V. Klim, DO
Lexington, KY

Associate Professor, Dept of Physical Medicine and Rehabilitation, and Medical Director of Community Rehabilitation Services, U of Kentucky. Medical Director, Summit Therapy Outpatient Services; Medical Director, Sub Acute Rehab Services, Vencor. DO, 1980, Philadelphia College of Osteopathic Medicine.

James W. Kincaid, MD

1859–1933



J. W. Kincaid
1915

At the Annual Meeting of the Kentucky State Medical Association held in Louisville, Jefferson County, Kentucky, on September 21-23, 1915, James W. Kincaid, MD, became its 59th President.¹

Kincaid, known by his initials "JW," was born to Dr James D. and Lenora Chapman Kincaid in Catlettsburg, Boyd County, Kentucky, on March 2, 1859.² He received his early education in local schools and at the East Kentucky Normal School (now Eastern Kentucky University, Richmond, KY). He received his MD in 1880 from the Medical College of Ohio in Cincinnati,³ and returning to his hometown began practice from his father's office. This was a small community of less than 500 persons in which his father had begun to practice in 1847 as one of the few early residents. The community continued to grow and by 1912, had a population of 3,500 residents. Dr J.W. Kincaid's practice focused upon, but was not limited to, surgery. He prospered as his talents and skills became known over the tri-state area of Kentucky, Ohio and West Virginia.

JW's name appears in the *Journal of the Kentucky State Medical Association* (JKSMA, now JKMA) beginning in 1914 and continuing for nearly a decade. He presented several papers on medical subjects and contributed often to the discussion of the papers presented by others. His interest and knowledge of surgery is apparent from his comments — especially concerning tuberculosis of lymph nodes, surgical complications of typhoid fever, and antiseptics.

His Presidential Address focusing upon medical ethics was carefully prepared and demonstrates his knowledge of the literature of medicine and the

role of ethics in the conduct of the physician with his patients and his confreres.⁴

As Dr Kincaid was completing his term in office, great changes were taking place in Europe as WWI was soon to involve the United States (war declared on Germany, April 6, 1917; first troops in Europe, June 26, 1917). In America, Congress passed the 18th ("Prohibition") Amendment to the Constitution on December 18, 1917, and submitted it for state ratification.⁵ As early as October 1916, at the KMA Annual Meeting in Hopkinsville, Kincaid had spoken against the customary use of alcohol in the treatment of disease.⁶

By the time of the Annual Meeting in Lexington, KY, on September 27-30, 1920, the 18th Amendment had become law⁷ and there was much discussion about the use and abuse of alcohol. Kincaid was still adamantly against the use of alcohol as a beverage⁸ but "welcomed whiskey as a pain reliever and a substitute for narcotics, and . . . it will take a frog out of the throat."⁹

During his professional lifetime he was also a Worthy Master of the Hampton Masonic Lodge, a member of the

Kiwanis and Rotary Clubs, and an active member of the Methodist Episcopal Church South of Catlettsburg.

Kincaid survived two wives, Emma Jeffers and Jennie Taylor, and was survived by his third wife, Jeanette Durbin. There were no children.

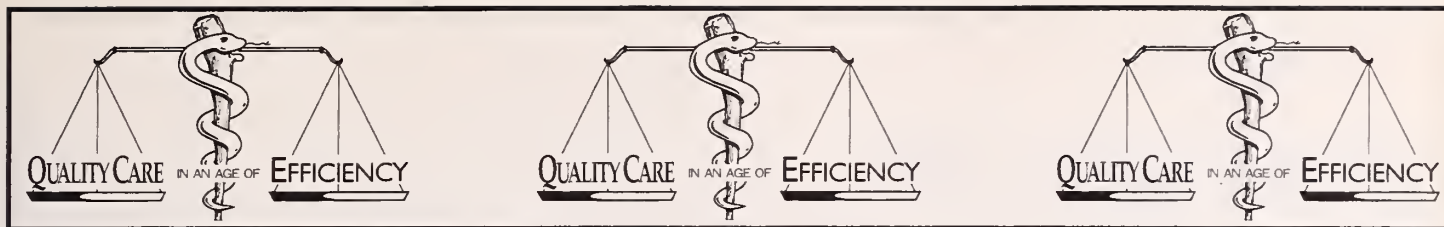
He died of heart disease while he and his wife were enroute to his retirement home in Bradenton, Florida. He was buried in the Catlettsburg cemetery following a service in the M E Church South in his hometown. No notice of his death was located in JKMA, but one did appear in JAMA.¹⁰

Dr Kincaid was much revered as a family physician as well as surgeon by his many patients in the tri-state area. It is appropriate that we, his professional descendants, should honor him at this Annual Meeting.

Eugene H. Conner, MD
KMA Historian

References

1. Kincaid JW. President's Address. The Relation of the Physicians to the Public, to Each Other and to the Patient. JKMA 1915;13:516-520.
2. Anon. "Final Tribute to Dr Kincaid." *Shland Daily Independent*. Sunday morning, December 24, 1933. 39, Section 1, p 16, cols (1 & 2).
3. Anon. Graduates of Medical College of Ohio, Cincinnati, March *Cincinnati Lancet and Clinic*, 1880 (March 2) 4.
4. Vide Supra #1, p 516.
5. *The World Almanac and Book of Facts*, 1995. Funk & Wagnalls Corp, Mahwah, NJ 1994. "Constitution of the United States, Amendment XVIII, Liquor Prohibition Amendment." p 162.
6. Crowe SW. Rational Management of Typhoid Fever JKMA 1917;15: p 81. Discussion by JW Kincaid.
7. Amendment XVIII ratified by 36 states (3/4 of 48) on 16 January 1919 & became law one year later, 16 January 1920.
8. Kincaid JW. Discussion JKMA 1920;18: p 478.
9. *Ibid*, p 497.
10. JAMA 1934 (3 Feb) 102, 390.



1996 KMA ANNUAL MEETING

Scientific Program

James W. Kincaid, MD, Meeting

Danny M. Clark, MD KMA President, Presiding

Friday, September 27, 1996
Morning General Session
General Sessions Area
Commonwealth Convention Center

- 8:30 AM Welcome and Announcements
- 8:40 AM **Hip Arthroscopy**
Joseph C. McCarthy, MD, Boston, Massachusetts
Kentucky Orthopaedic Society
- 9:00 AM **New Concepts in the Renin Angiotensin System — Tissue ACE**
Jose S. Martinez, MD, Lakeland, Florida
Kentucky Chapter, American College of Chest Physicians
- 9:20 AM **Ophthalmology Outcomes Research and Quality of Care**
Stephen A. Obstbaum, MD, Leonia, New Jersey
Kentucky Academy of Eye Physicians and Surgeons
- 9:40 AM **The Microsurgical Treatment of Extensive Chronic Boney Wounds**
James W. May, MD, FACS, Boston, Massachusetts
Kentucky Society for Plastic and Reconstructive Surgery
- 10:00 AM **Intermission to visit exhibits**
- 10:30 AM **Goal-Directed Approach to Erectile Dysfunction**
Tom F. Lue, MD, San Francisco, California
Kentucky Urological Society
- 10:50 AM **Skull Base Surgery in an Age of Efficiency**
Ossama Al-Metty, MD, Little Rock, Arkansas
Kentucky Neurosurgical Society
- 11:10 AM **Differentiation of Wide Complex Tachycardias**
Marshall Stanton, MD, Rochester, Minnesota
Kentucky Chapter, American College of Physicians
- 11:30 AM **To What Extent is the Specialist an Answer to the Generalist Shortage?**
Hiram C. Polk, MD, Louisville, Kentucky
Kentucky Chapter, American College of Surgeons
- 11:50 PM Adjourn

KY Urological Society

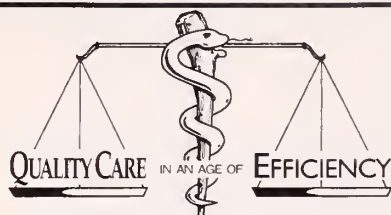
Convention Center
Meeting Room — 106
Friday, September 27

- 1:30 PM **Surgical Treatment of Peyronie's Disease and Priapism**
Tom F. Lue, MD
- 2:30 PM **Pyelogram Hour**
- 3:30 PM **Intermission to visit exhibits**
- 4:00 PM **Business Meeting**
- 5:00 PM Adjourn

KY Chapter, American College of Physicians

Convention Center
Meeting Room — 105
Friday, September 27

- 1:30 PM **Associates' Presentations**
University of Kentucky and University of Louisville
- 2:30 PM **Evaluation and Management of Chest Pain — 1996**
Joseph A. Lash, MD, FACC
- 3:15 PM **Intermission to visit exhibits**
- 3:30 PM **Management of Atrial Fibrillation**
Marshall Stanton, MD
- 4:15 PM **Management of Congestive Heart Failure**
Bill H. Harris, MD
- 5:00 PM Adjourn



KY Neurosurgical Society

Convention Center
Meeting Room — 109
Friday, September 27

- 1:00 PM **Cavernous Sinus Surgery**
Ossama Al-Mefty, MD
- 2:00 PM **Electron Microscopy as Predictor of Recurrence: A Retrospective Study of Brain Meningioma**
John J. Guarneschelli, MD; David A. Petruska, MD; Wayne G. Villaneuva, MD; Stan Stawicki, BS
- 2:15 PM **Intratumor Chemotherapy for Malignant Gliomas**
Byron Young, MD; Roy Patchell, MD
- 2:30 PM **Intermission to visit exhibits**
- 2:45 PM **Fifty Years of Neurosurgery in Louisville**
Christopher B. Shields, MD; George H. Raque Jr, MD; Henry D. Garretson, MD
- 3:00 PM **Just How Selective is Selective Posterior Rhizotomy?**
Benjamin C. Warf, MD
- 3:15 PM **Stereotactic Operating-Arm System: A Comparison Study to Intraoperative B-Mode Ultrasound for Intracranial Tumors**
John J. Guarneschelli, MD; David A. Petruska, MD; Wayne G. Villaneuva, MD; Stan Stawicki, BS
- 3:30 PM **Cranial Interactive Image Guided Surgery**
Paul K. Gardner, MD; Andrew Reisner, MD
- 3:45 PM **Biomechanics of the Thoracolumbar Junction**
Deborah Blades, MD
- 4:00 PM **Use of Biocompatible "Hydrogels" to Bridge Transected Rat Spinal Cord**
Michael J. Doyle, MD; Yi Ping Zhang, MD; Timothy C. Slesnick; Dante J. Morassutti; David S. K. Magnuson; Stefane Woerly; Christopher B. Shields, MD
- 4:15 PM **Approaches to Tumors of the Clivus**
Ossama Al-Mefty, MD
- 5:00 PM **Business Meeting**

KY Society for Gastrointestinal Endoscopy

Convention Center
Meeting Room — 103
Friday, September 27

- 1:00 PM **Management Strategies and a Case Report of Mucinous Ductal Ectasia of the Pancreas**
Whitney Jones, MD; Jon W. Jones, MD
- 1:15 PM **Menetrier's Disease: Case Presentation**
Ewell G. Scott, MD
- 1:30 PM **Diagnostic Characteristic of Non Alcoholic Steatohepatitis**
Carlo Tamburro, MD; Sriprakash Mokshagundam, MD
- 1:45 PM **Complications of Colonoscopy at a Teaching Hospital: Implications of Quality Assurance**
Susan Galandiuk, MD; Pasha Ahmad, MD
- 2:00 PM **Endoscopic Treatment of "Smoldering" Pancreatitis**
Raja M. Kaikau, MD; Joseph E. Geenen, MD
- 2:15 PM **Hepatic Drug Metabolism in a Human Sepsis Model**
Steven I. Shedlofsky, MD; Raina T. Tosheva, MD; Robert A. Blouin, MD
- 2:30 PM **Current Management of Bleeding Esophageal Varices**
Greg V. Stiegmann, MD
- 3:15 PM **Intermission to visit exhibits**
- 3:30 PM **PDT in Esophageal Cancer**
T. Jeffery Wieman, MD; Scott W. Taber, MD; Victor Fingar, MD
- 3:45 PM **Endoscopic Drainage of Pancreatic Pseudocyst**
David Harrell, MD; Gary C. Vitale, MD
- 4:00 PM **Endoscopic Ultrasonography**
Leor Rouben, MD
- 4:15 PM **Serum-to-Ascites Amylase Ratio: A Predictor of Mortality in Acute Pancreatitis**
Laurie S. Haas, MD; Lawrence K. Gates, MD
- 4:30 PM **Endoscopic Balloon Dilation of the Esophagus in Children**
Yuhanna Al-Tawil, MD
- 4:45 PM **Treatment of Inflammatory Bowel Disease: Emerging Concepts**
Gary W. Varilek, MD
- 5:00 PM **Adjourn**

CME

AMERICAN ACADEMY OF FAMILY PHYSICIANS
This program has been reviewed and is acceptable for 12 Prescribed hours by the AAFP. AAFP Prescribed credit is accepted by the AMA as equivalent to AMA PRA Category 1 for the AMA Physicians Recognition Award. When applying for the AMA PRA, Prescribed hours earned must be reported as Prescribed hours, not as Category 1.

Kentucky Chapter, American College of Cardiology Dinner Meeting, Vincenzo's Restaurant on Friday, September 27, at 6:30 pm. Speaker: Sylvan L. Weinberg, MD, former President, ACC "Health Care Reform: Impact on Practice, the Profession and Truth."

1996 Annual Meeting

KY Academy of Physical Medicine and Rehabilitation

Convention Center
Meeting Room — 113
Friday, September 27

- 1:30 PM **Annual Business Meeting**
- 2:00 PM **Resident Research Presentations**
University of Louisville and
University of Kentucky
- 3:00 PM **Intermission to visit exhibits**
- 3:30 PM **The Physiatrist as Patient Advocate in the
Medical Legal System**
Gerald V. Klim, DO
- 4:30 PM **Adjourn**

KY Chapter, American College of Chest Physicians

Convention Center
Meeting Room — 110
Friday, September 27

- 1:30 PM **A Clinical Approach to the Treatment of
Hypertension — A Focus on End Organ Disease**
Jose S. Martinez, MD
- 2:15 PM **Lung Reduction**
Stephen S. Lefrak, MD
- 3:00 PM **Intermission to visit exhibits**
- 3:30 PM **Angiotension II Tissue Problems and the Effects
of Losartan**
Edward D. Frohlich, MD
- 4:15 PM **Noninvasive Ventilation: What is it Good For?**
Nicholas S. Hill, MD
- 5:00 PM **Adjourn**

Educational grants have been provided by the following:
Jose S. Martinez, MD — Parke-Davis
Edward D. Frohlich, MD — Merck & Co, Inc
Nicholas S. Hill, MD — Boehringer Ingelheim

KY Chapter American College of Emergency Physicians

Convention Center
Meeting Room — 107
Friday, September 27

- 12:00 PM **Lunch**
- 1:30 PM **Tactical Emergency Medicine**
David Rasumoff, MD
- 2:30 PM **Kentucky ACEP Meeting**
- 3:30 PM **Adjourn**

KY Orthopaedic Society

Convention Center
Meeting Room — 112
Friday, September 27

- 1:30 PM **Welcoming Comments**
Jeffrey W. Parr, MD, President
- 1:35 PM **Business Meeting**
Jeffrey W. Parr, MD
- 1:55 PM **Practice Patterns in Revision THR: Where We
Have Been and Where We Are Going**
Joseph C. McCarthy, Jr, MD
- 2:20 PM **Bone Densitometry in the Diagnosis of
Osteoporosis**
Theresa M. Corrigan, MD
- 2:40 PM **Ultrasonography of the Shoulder for Rotator
Cuff Tears**
Craig S. Roberts, MD
- 3:00 PM **Intermission to Visit Exhibits**
- 3:30 PM **Current Management of Bone Tumors**
Robert E. Wolf, MD
- 3:50 PM **Results of Acetabular Grafting in Primary and
Revision Surgery**
Donald L. Pomeroy, MD
- 4:10 PM **Arthroscopic Treatment of Shoulder Instability**
Frank O. Bonnarens, MD
- 4:30 PM **PCL Insertion Site Anatomy and Clinical
Implications**
Scott D. Kuiper, MD
- 4:50 PM **Current Status of Health Care in Kentucky**
Steven L. Henry, MD, Lieutenant Governor
Commonwealth of Kentucky
- 5:10 PM **Computer Presentation**
- 5:25 PM **Councilor's Report**
Scott B. Scutchfield, MD
- 5:30 PM **Adjourn**
- 6:15 PM **Reception at Vincenzo's Restaurant**
- 7:00 PM **Dinner at Vincenzo's Restaurant**

KY Dermatological Society

310 East Broadway
Louisville, Kentucky
Friday, September 27

- 12:30 PM **Registration**
- 1:00 PM **Patient Presentation**
- 2:00 PM **Intermission to visit exhibits**
- 2:30 PM **Case Discussion**
- 3:30 PM **Vulvar Disorders**
Marilynne McKay, MD
- 4:30 PM **Adjourn**



KY Academy of Eye Physicians and Surgeons

Convention Center
Meeting Room — 108
Friday, September 27

- 1:40 PM **Intracameral Anesthesia for Cataract Surgery**
Lloyd Taustine, MD
- 2:00 PM **A Vision for the Future of Ophthalmology**
Stephen Obstbaum, MD
- 2:45 PM **PRK with the Medifec Scanning Excimer Laser**
Richard Eiferman, MD
- 3:00 PM **Intermission to visit exhibits**
- 3:30 PM **Complications of Small Clear Zone Radial Keratotomy**
Michael Grimmett, MD
- 3:45 PM **Submacular Surgery**
William Wood, MD
- 4:00 PM **CO2 Laser Periocular Rejuvenation**
William Offott, MD
- 4:15 PM **Business Meeting**
- 4:45 PM **Adjourn**

KY Society for Plastic & Reconstructive Surgery

Convention Center
Meeting Room — 111
Friday, September 27

- 1:30 PM **President's Welcome**
Bruce A. MacDougall, MD, FACS
- 1:45 PM **Breast Reconstruction After Mastectomy**
James W. May, MD, FACS
- 2:30 PM **Long Term Follow-Up After Myelomeningocele**
Timothy Wilson, MD
- 2:45 PM **Mitek Fixation in the Phalanx**
Sam Kao, MD
- 3:00 PM **Early Excision of Grafting vs Conservative Management in Burns of the Elderly**
David Kirn, MD
- 3:15 PM **Intermission to visit exhibits**
- 3:45 PM **Update on the Educational Foundation**
Kenna Given, MD, FACS
- 4:00 PM **Endoscopic Carpal Tunnel Update**
Bruce A. MacDougall, MD, FACS
- 4:15 PM **Legislative Report: ASPRS in Washington**
Lee B. Daniel, MD, FACS
- 4:30 PM **Breast Reconstruction Advocacy**
Christine Horner-Taylor, MD, FACS
- 5:00 PM **Adjourn**

KY Chapter, American College of Surgeons

Convention Center
Meeting Room — General Sessions
Friday, September 27

- 1:30 PM **An Expanded Scope of Practice for General Surgery**
Hiram K. Polk, Jr, MD
- 2:15 PM **Deep Venous Thrombosis**
Thomas Bergamini, MD
- 2:50 PM **Postoperative Pneumonia in the Surgical Patient**
Shaun A. Price, MD
- 3:10 PM **Role of Extracorporeal Circulation in Liver Transplantation**
Solly Mizrahi, MD
- 3:30 PM **Surgical Education**
Richard Schwartz, MD
- 3:50 PM **The Impact of Level III Verification on Trauma Admissions and Transfers: Comparison of Two Rural Hospitals**
J. David Richardson, MD
- 4:10 PM **Lung Transplantation**
Robert D. Dowling, MD
- 4:30 PM **Contemporary Management of Papillary Thyroid Cancer**
David A. Sloan, MD
- 4:45 PM **Adjourn**

1996 Annual Meeting

James L. Borders, MD Chair Scientific Program Committee Presiding

Saturday, September 28, 1996
General Sessions Area
Commonwealth Convention Center

- 8:30 AM **Welcome and Announcements**
8:40 AM **The Effect of Managed Care on Physician and Hospital Utilization**
Gerard Rabalais, MD, Louisville, Kentucky
Kentucky Pediatric Society
9:00 AM **Is Patient Request Sufficient Reason for Major Conduction Analgesia (spinal/epidural) for Routine Labor and Delivery?**
Brett Gutsche, MD, Philadelphia, Pennsylvania
Kentucky Society of Anesthesiologists
9:30 AM **Is Atopic Dermatitis an Allergic Disease**
Donald Y.M. Leung, MD, PhD, Denver, Colorado
Kentucky Society of Allergy, Asthma, and Clinical Immunology
10:00 AM **Intermission to visit exhibits**
10:30 AM **How to Induce Ovulation with Clomiphene Citrate: Perspectives of a 20-Year Practice**
Eli Adashi, MD, Baltimore, Maryland
Kentucky OB/GYN Society — Kentucky Section ACOG
10:50 AM **Violence: A New Medical Epidemic**
Peter G. Stringham, MD, East Boston, Massachusetts
Kentucky Chapter, American Academy of Family Physicians
11:10 AM **Does the Autopsy Contribute to Quality Care Today?**
Peter Baker, MD, Columbus, Ohio
Kentucky Society of Pathologists
11:30 AM **Inpatient Treatment of Alcohol Detoxification Under Managed Care**
Harold Eist, MD, Washington, DC
Kentucky Psychiatric Association
11:50 AM **Adjourn**

President's Installation & Awards Luncheon

Saturday, September 28, 1996 -- 11:50 am
Regency Ballroom - Hyatt Regency Hotel

Danny M. Clark, MD KMA President, presiding

Invocation

Recognition

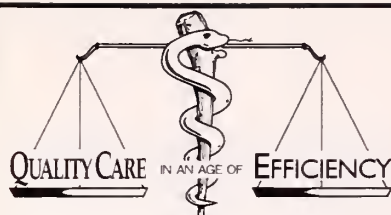
Awards Presentation

Ardis D. Hoven, MD, Lexington
Chair, KMA Awards Committee
Installation of William H. Mitchell, MD
KMA President 1996-97

KY OB/GYN Society — KY Section ACOG

Convention Center
Meeting Room — General Sessions
Saturday, September 28

- 1:30 PM **Is Bilateral Ovarian Resection Really an Option in the Context of the Polycystic Ovarian Syndrome?**
Eli Adashi, MD
2:15 PM **Screening for Cancers by Gynecologists**
David Doering, MD
2:45 PM **Diagnosis and Management of Fecal Incontinence**
Michael Heit, MD
3:15 PM **Q & A**
3:30 PM **Intermission to visit exhibits**
3:50 PM **Current GBS Protocols**
Joseph A. Spinnato, MD
4:20 PM **Active Management of Labor**
Vernon Cook, MD
4:50 PM **Adjourn**



KY Psychiatric Association

Convention Center
Meeting Room — 110
Saturday, September 28

- 2:00 PM **KPA General Meeting**
- 2:15 PM **Psychiatry and Managed Care**
Harold Eist, MD
- 3:15 PM **Intermission to visit exhibits**
- 3:30 PM **The Kentucky Impact Program (A Program for Emotionally Disturbed Children)**
Edward Maxwell, MD
- 4:30 PM **Adjourn**

KY Association of Public Health Physicians

Convention Center
Meeting Room — 104
Saturday, September 28

- 1:45 PM **KAPHP Business Meeting**
- 2:15 PM **Prevention of Antibiotic Overuse**
Reginald Finger, MD and Arch G. Mainous, III, PhD
- 4:15 PM **Adjourn**

KY Pediatric Society

Convention Center
Meeting Room — 105
Saturday, September 28

- 2:15 PM **Managed Care in the Practice of Pediatrics**
Gerard Rabalais, MD
- 3:15 PM **Intermission to visit exhibits**
- 3:45 PM **Developing Patterns of Antimicrobial Resistance — Importance to the Primary Pediatrician**
Chris Nelson, MD
- 4:30 PM **Adjourn**

Commonwealth Neurological Society

Convention Center
Meeting Room — 102
Saturday, September 28

- 2:15 PM **Neuroimmunology of Multiple Sclerosis**
Barry G. W. Arnason, MD
- 3:15 PM **Business Meeting**
- 4:30 PM **Adjourn**

KY Geriatrics Society

Convention Center
Meeting Room — 112
Saturday, September 28

- 2:15 PM **Managed Care — Re-engineering Medicare**
Matthew F. Emons, MD
- 3:00 PM **Intermission to visit exhibits**
- 3:30 PM **Foot Problems in the Elderly**
Lisa DeGnore, MD
- 4:15 PM **Business Meeting**
- 5:00 PM **Adjourn**

KY Chapter American Academy of Family Physicians

Convention Center
Meeting Room — 106
Saturday, September 28

- 2:15 PM **Raising Children who are Safer in a Violent World (What a Doctor can do in his Office to Decrease Violence)**
Peter G. Stringham, MD
- 3:00 PM **Intermission to visit exhibits**
- 3:45 PM **Raising Children who are Safer in a Violent World (What a Doctor can do in his Office to Decrease Violence)**
Peter G. Stringham, MD
- 4:30 PM **Adjourn**

KY Society of Pathologists

Convention Center
Meeting Room — 109
Saturday, September 28

- 2:15 PM **Taking a Peak at Current Autopsy Practices Through College of American Pathologist's Q-Probes Studies**
Peter Baker, MD
- 3:15 PM **Intermission to visit exhibits**
- 3:45 PM **Autopsy Performance and Reporting: Case Studies in Cardiovascular Pathology**
Peter Baker, MD
- 4:45 PM **Business Meeting**
- 5:15 PM **Adjourn**

1996 Annual Meeting

KY Society of Allergy, Asthma, and Clinical Immunology

Convention Center
Meeting Room — 107
Saturday, September 28

- 2:15 PM **Management of the Severe Asthmatic**
Donald Y. M. Leung, MD, PhD
- 3:00 PM **Intermission to visit exhibits**
- 3:15 PM **Business Meeting**
- 4:00 PM **Adjourn**

KY Society of Anesthesiologists

Convention Center
Meeting Room — 108
Saturday, September 28

- 2:15 PM **Recent Advances in Spinal and Epidural
Analgesia and Anesthesia for Obstetrics**
Brett B. Gutsche, MD
- 3:05 PM **Current Controversies in Obstetric Anesthesia**
Gerard M. Basell, MD
- 3:55 PM **Panel: Problem Cases in OB Anesthesia**
Brett B. Gutsche, MD; Gerard Basell, MD; and
Aparna Mankad, MD
- 4:40 PM **Business Meeting**
- 5:20 PM **Reception**
- 6:00 PM **Adjourn**

KY Occupational Medical Association

Convention Center
Meeting Room — 103
Saturday, September 28

- 2:15 PM **Challenges of the Future**
Kent W. Peterson, MD, FACOEM
- 3:15 PM **The Pure Tone Audiogram — Strengths and
Pitfalls**
William Green, PhD
- 4:15 PM **Expectations of a Managed Care Organization**
Rosalie Faris, RN, CCM, COHNS
- 5:00 PM **Adjourn**

Kentucky Society of Otolaryngology Head & Neck Surgery, Inc

Convention Center
Meeting Room — 111
Saturday, September 28

- 2:15 PM **TBA**

A Computer Center sponsored by the ACP will be open 10:00 AM to 6:00 PM, in Room 117 at the Convention Center on Friday and Saturday, September 27-28, 1996, for hands-on demonstrations and use. The following program will be only on Saturday, September 28.

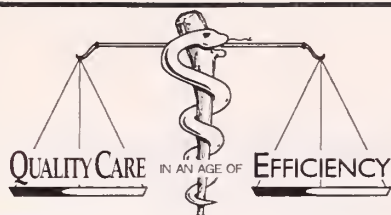
- 2:00 PM **Computers in Medicine I**
Lawrence Blonde, MD, FACP
- 3:00 PM **Intermission to visit exhibits**
- 3:15 PM **Computers in Medicine II**
Thomson M. Kuha, MA
- 4:15 PM **Q & A**
- 4:30 PM **Adjourn**

*** Limited admission available*

CONTINUING MEDICAL EDUCATION

The Kentucky Medical Association designates this continuing medical education activity for 12 credit hours in Category 1 of the Physician Recognition Award of the American Medical Association. One credit hour may be claimed for each hour of participation by the individual physician.

The Kentucky Medical Association is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.



General Sessions Learning Objectives

KY CHAPTER, AMERICAN COLLEGE OF SURGEONS

To What Extent is the Specialist an Answer to the Generalist Shortage?

Hiram C. Polk, MD

Participants will review the historical aspects of specialty differentiation, especially in general surgery, and discuss the present scope of practice of many general surgeons, especially in smaller cities.

KY CHAPTER, AMERICAN ACADEMY OF FAMILY PHYSICIANS

Violence: A New Medical Epidemic

Peter Stringham, MD

Participants will briefly review the problem of violence from a medical perspective, and analyze a psychological model which doctors find useful for intervention in and prevention of youth violence. Participants will observe that people are on a continuum for violence (as in IQ) and will review relevant research into how people at different ends of the continuum view conflict and handle conflict. Participants can explore the concept of "nonviolent problem solvers" who confront conflict and resolve difficult situations nonviolently.

KENTUCKY UROLOGICAL SOCIETY

Goal-Directed Approach to Erectile Dysfunction

Tom F. Lue, MD

Participants will review the patient's goal-directed approach to erectile dysfunction. The participants will assess pharmacological management of erectile dysfunction, its side effects and medical treatment of priapism.

KENTUCKY SOCIETY FOR PLASTIC AND RECONSTRUCTIVE SURGERY

The Microsurgical Treatment of Extensive Chronic Boney Wounds

James W. May, Jr, MD

Participants will review the clinical evaluation of wounds and their relationship to bone involvement; the diagnosis of extent of boney wound involvement; appropriate soft tissue treatment options for the microsurgical implementation and treatment of chronic boney wounds; and the outcome of microsurgical treatment of chronic boney wounds.

KY ACADEMY OF EYE PHYSICIANS AND SURGEONS

Ophthalmology Outcomes Research and Quality of Care Initiatives

Stephen A. Obstbaum, MD

Participants will interpret the principles of outcomes assessment and review ongoing activities in outcomes data collection and quality assessment in the specialty of ophthalmology.

KY CHAPTER, AMERICAN COLLEGE OF PHYSICIANS

Differentiation of Wide Complex Tachycardias

Marshall S. Stanton, MD

Participants will recognize the differential diagnosis of wide complex tachycardia and will discuss a logical approach to interpreting wide complex tachycardias.

KY OB/GYN SOCIETY KENTUCKY SECTION ACOG

How to Induce Ovulation with Clomiphene Citrate: Perspectives of a 20-Year Practitioner

Eli Adashi, MD

Participants will review case studies and clinical results of the effects of Clomiphene Citrate on ovulation and the considerations for proper management.

KY SOCIETY OF PATHOLOGISTS

Does the Autopsy Contribute to Quality Care Today?

Peter Baker, MD

Participants will review ongoing practices in quality care assessment and define the integral aspects which the autopsy contributes towards quality medicine.

KY SOCIETY OF ALLERGY, ASTHMA & CLINICAL IMMUNOLOGY

Is Atopic Dermatitis an Allergic Disease?

Donald Y.M. Leung, MD, PhD

The participants will learn about the triggers of Atopic Dermatitis, including the role of allergens. In addition, they will examine the cellular and immunologic mechanisms that may play an important role in the pathogenesis of chronic Atopic Dermatitis, and they will review the clinical management of Atopic Dermatitis.

KY PEDIATRIC SOCIETY

The Effect of Managed Care on Physician and Hospital Utilization

Gerard Rabalais, MD

Participants will assess the changing demands being placed on the health care system and analyze how integration of services and providers will be impacted based on patients' wants and needs.

KY PSYCHIATRIC ASSOCIATION

Inpatient Treatment of Alcohol Detoxification Under Managed Care

Harold Eist, MD

Participants will learn how managed care is affecting the quality and economy of medical practice in the area of inpatient treatment of alcohol detoxification.

KY ORTHOPAEDIC SOCIETY

Hip Arthroscopy

Joseph C. McCarthy, MD

The participants will review information on the efficacy, cost, and results of hip arthroscopy, and analyze new advances.

KY NEUROLOGICAL SOCIETY

Skull Base Surgery in an Age of Efficiency

Ossama Al-Mefty, MD

Participants will critique the elements of skull base surgery in the age of managed care and limited resources in health care delivery.

KY CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

New Concepts in the Renin Angiotensin System — Tissue ACE

Jose S. Martinez, MD

Participants will review the historical concepts and will assess new concepts related in the Renin Angiotensin System — Tissue ACE.

KY SOCIETY OF ANESTHESIOLOGISTS

Is Patient Request Sufficient Reason for Major Conduction Analgesia (Spinal/Epidural) for Routine Labor and Delivery?

Brett B. Gutsche, MD

The participants will assess the need for major conduction analgesia and the rationale for administration of the analgesia during labor and delivery.

"Be Our Guest"

*If you are a physician aged 40 years
or younger, or if you've been
in practice 5 years or less...*

*Be our guest and join your colleagues at a
luncheon being held during the
Kentucky Medical Association's
Annual Meeting*

Friday, September 27, 1996

12:00 noon

*Keeneland Suite - Hyatt Regency, Louisville
(Spouses welcome)*

Make Plans To Attend!

AN INVITATION TO ALL SENIOR AND/OR RETIRED MEMBERS OF KMA
TO THE STATEWIDE CATO SOCIETY MEETING
OF THE SENIOR PHYSICIANS OF
JEFFERSON COUNTY

9:30 AM

SATURDAY, SEPTEMBER 28, 1996
THE HYATT REGENCY HOTEL, LOUISVILLE, KY

Here is an opportunity for senior and/or retired members of KMA to meet old colleagues and make new friends at the 7th Annual Statewide CATO Society Meeting, held during the KMA Annual Meeting. This year the CATO Society meeting will be held at the Hyatt Regency Hotel in Louisville, Kentucky. It will begin with breakfast at 9:30 AM in the Keeneland Suite.

The CATO Society is an integral part of the Jefferson County Medical Society and its Senior Physicians Committee. We have meetings in the Spring and Fall that are primarily for fellowship. We gather for a light meal followed by an enlightening but brief address on some informative or entertaining topic.

Last year's meeting was an immense success with a large crowd of senior physicians from the Kentuckiana area.

Again this year, we cordially invite spouses and widows to attend.

Watch the mail for your invitation, complete the form, and share a time during breakfast with your colleagues. We look forward to visiting with you.

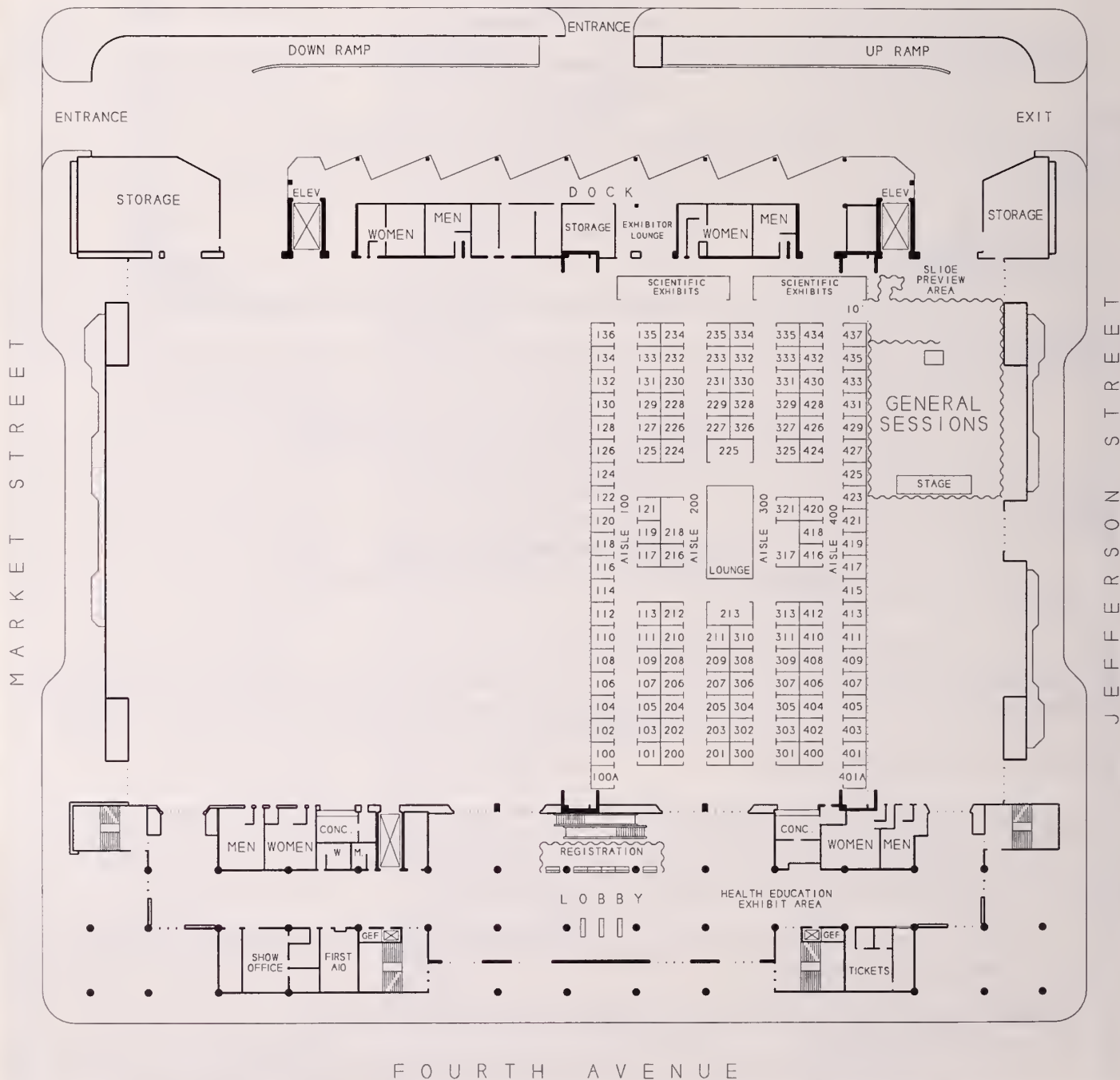
Eugene H. Conner, MD
President, Jefferson County CATO Society

EXHIBIT HALL FLOOR PLAN

COMMONWEALTH CONVENTION CENTER

LOUISVILLE, KENTUCKY

THIRD STREET



All exhibitors with corresponding booth space(s) are listed on this map of the Exhibit Hall. We regret that due to printing and publication deadlines, not all exhibitors are represented in this Exhibit Guide. For more detailed information on the exhibitors, refer to the Technical Exhibits listing beginning on page 355, and please visit them in the Exhibit Hall.

TECHNICAL EXHIBITOR DIRECTORY

| Exhibitor | Booth | Exhibitor | Booth |
|----------------------------------------------|-------|------------------------------------------------|-------|
| ASI, Inc | 235 | Kentucky Spine Institute | 310 |
| Abbott Laboratories | 200 | Key Pharmaceutical | 425 |
| AchillesHEAL | 321 | Lexington Diagnostic Center | 432 |
| AdminaStar Federal | 216 | Lincoln Trail Behavioral Health System | 401 |
| Air Force Health Professions | 101 | Mark Kidd Studios | 325 |
| Alliant Health System | 302 | Mead Johnson Nutritionals | 301 |
| The Almont Group | 300 | The Medical Protective Company | 225 |
| American Cancer Society, KY Division | 428 | Merck and Co, Inc | 417 |
| Anthem Blue Cross-Blue Shield | 211 | Money Concepts | 124 |
| Appalachian Regional Healthcare | 201 | Norton Hospital Cancer Treatment Center | 402 |
| Astra Merck, Inc | 403 | Norton Psychiatric Clinic | 415 |
| Astra, USA | 234 | Olympus America | 210 |
| Baptist Healthcare Systems | 429 | The PIE Mutual Insurance Co | 416 |
| Bank of Louisville | 335 | The Pain Institute | 412 |
| Bayer Corporation | 420 | Pfizer Labs | 431 |
| Berlex Laboratories | 424 | Pikeville Methodist Hospital | 203 |
| Cardinal Hill Rehabilitation Hospital | 135 | Procter and Gamble | 100 |
| Chilton & Medley, PLC, CPA | 305 | RCFA Healthcare Management Services | 131 |
| Clayton L. Scroggins Associates, Inc | 427 | Ransdell Surgical, Inc | 227 |
| Columbia/HCA | 313 | Rexall Showcase International | 327 |
| Division of Disability Determinations | 430 | Roerig, a Division of Pfizer | 334 |
| Eli Lilly and Company | 434 | Royal Bank of Canada | 433 |
| Floyd Memorial Hosp. & Health Services | 326 | Saint Joseph Hospital | 426 |
| Fujisawa USA, Inc | 103 | Service Employee Leasing, Inc | 114 |
| Greentree Applied Systems | 419 | SmithKline Beecham Clinical Laboratories | 226 |
| Grogan's, Inc | 224 | SmithKline Beecham Pharmaceuticals | 233 |
| Health Care Excel, Inc | 435 | Southeastern Data Systems | 437 |
| Infectious Disease Control, Inc | 401A | Southern Medical Association | 304 |
| Jefferson Co Medical Society Prof Svcs | 202 | Sterling Healthcare Group | 117 |
| Jewish Hospital Healthcare Services | 100A | United Leasing, Inc | 125 |
| Kentucky Air National Guard | 303 | University of Kentucky Hospital | 400 |
| Kentucky Army National Guard | 311 | Vanderbilt University Medical Center | 113 |
| Kentucky Eagle Energy Company | 423 | Visiting Nurse Association | 413 |
| Kentucky Hospital Insurance Agency | 421 | Wheat First Butcher Singer | 418 |
| Kentucky Medical Ins Co/KMA Ins Agency | 218 | Wyeth-Ayerst Laboratories | 212 |
| Kentucky Organ Donor Affiliates | 111 | | |

Plan to visit the Exhibit Hall during the KMA Annual Meeting. Trained professional representatives will be on hand to discuss with you the details of their products and services in a relaxed atmosphere — with no patients waiting in your outer office and with no telephones ringing. Located in the Commonwealth Convention Center, the exhibits will condense a volume of information and ideas in such a manner that a vast amount of knowledge can be secured in a short period of time.

The Exhibit Hall is an important part of the Annual Meeting and is the site of registration for all CME courses.

Thirty-minute intermissions have been planned during each general and specialty group sessions so that every physician may take advantage of this opportunity to benefit their practice and their patients.

ASI, Inc (Ahead Staffing, Inc) #235

2207 Heather Lane
Louisville, KY 40218
(502) 485-1000

ASI, Inc is a specialty business offering a Professional Employer Organization. ASI, Inc provides employers with a complete Human Resource department by handling their payroll, employee administration, benefits, workers compensation, and unemployment. Outsourcing personnel administration allows someone else to handle the nonproductive functions of maintaining employees, allotting more time to focus on practicing medicine.

Abbott Laboratories #200

200 Abbott Park Road
Dept 304, Bldg AP30/4W
Abbott Park, IL 60064
(847) 937-3281

You are invited to visit the Abbott Laboratories exhibit where representatives will be on hand to answer your questions regarding Biaxin® (clarithromycin) Tablets and For Oral Suspension, and our other pharmaceutical products.

AchillesHEAL #321

215 McDowell Road
Lexington, KY 40502-1821
(606) 266-9109

AchillesHEAL is a Kentucky based wound care supplies and medical equipment company specializing in equipment and services to "prevent, treat, and heal" wounds. Our services include the treatment and management of: pressure ulcers, venous stasis ulcers, diabetic ulcers, surgical ulcerations, peripheral vascular disease, lymphedema, post-mastectomy edema, pain and edema, limited range of motion, chronic venous insufficiency.

AdminaStar Federal #216

9901 Linn Station Road
Louisville, KY 40223-3824
(502) 425-7776
(502) 329-8500

Medicare Fiscal Intermediary and Carrier for the Commonwealth of Kentucky.

Air Force Health Professions #101

2515 Perimeter Place Drive
Nashville, TN 37214-3671
(615) 889-0723

Recruitment of Air Force Health Professionals—physicians.

Alliant Health System #302

PO Box 35070
Louisville, KY 40232-5070
(502) 629-8652

Lighted Skyline Display with Hospital Logo. Printed Brochures and pamphlets of services and physician services. Registered Nurses from the Physician Services Department will be in attendance.

The Almont Group #300

67 Prospect Avenue
West Hartford, CT 06106
(800) 289-9207

Tax reduction strategies developed especially for Medical Practitioners. We can show you and your accountant how to reduce your income tax liabilities on practice income, portfolio investment income, passive activities, annuity income, and on distributions from qualified retirement plans. Also available are techniques to make all of your life insurance premiums tax deductible.

American Cancer Society, Kentucky Division #428

701 W Muhammad Ali Blvd, PO Box 1807
Louisville, KY 40201-1807
(502) 584-6782

Provide information on The American Cancer Society, Kentucky Division, Inc's Breast Cancer Detection and Community Connection: Resources, Information and Guidance Core Programs.

Anthem Blue Cross-Blue Shield #211

9901 Linn Station Rd
Louisville, KY 40223
(502) 423-2298

Appalachian Regional Healthcare, Inc #201

1220 Harrodsburg Road, PO Box 8086
Lexington, KY 40533
(606) 226-2528

Appalachian Regional Healthcare, Inc is a not-for-profit healthcare system which includes 11 hospitals, 15 ambulatory clinics and 11 home health agencies. All facilities are located in the beautiful mountain regions of eastern Kentucky, West Virginia, and Virginia. ARH is seeking primary care and specialty physicians for its various medical staffs. Flexible practice options available.

Astra Merck #403
5110 Maryland Way #190
Brentwood, TN 37027
(615) 371-5288

Astra, USA #234
S Otis St
Westboro, MA 01581
(800) 225-6333

Bank of Louisville #335
500 West Broadway
Louisville, KY 40201
(502) 562-5469
Bank of Louisville Equipment Leasing. We offer lease programs for all types of equipment including general office equipment, medical equipment such as lasers or other medical machinery.

Baptist Healthcare System #429
4007 Kresge Way
Louisville, KY 40207
(502) 896-5059
An exhibit highlighting the services available at the fine Baptist hospitals in Kentucky as well as practice opportunities throughout the state.

Berlex Laboratories #424
300 Fairfield Road
Wayne, NJ 07470
(201) 694-4100
Please visit our booth to discuss our line of Female Healthcare products and our complete product line.

Cardinal Hill Rehabilitation Hospital #135
2050 Versailles Road
Lexington, KY 40504
(606) 254-5701
Cardinal Hill Rehabilitation Hospital provides comprehensive, state-of-the-art rehabilitative care to patients with physical and cognitive disabilities of all severity levels. Our booth will provide information on rehabilitation services and programs we offer at Cardinal Hill.

Chilton & Medley PLC, CPA #305
1100 Starks Building
Louisville, KY 40202
(502) 587-1719
Chilton & Medley PLC is a certified public accounting and consulting firm with a specialty in providing services to individuals and organizations in the healthcare industry. Since 1988, we've been helping physicians and office staff navigate their way to success in the healthcare marketplace. The members of Chilton & Medley's Medical Services Group possess unique and extensive backgrounds encompassing all aspects of accounting, tax, and practice management services.

Columbia/HCA Healthcare Corp #313
201 West Main Street, 8th Floor
Louisville, KY 40202
(502) 572-2887

Columbia is the largest provider of healthcare services in Kentucky. There are 13 hospitals, 5 home health agencies, and 2 surgery centers. It operates about 40 physician offices through its affiliate services.

Our hospitals are known for their work in innovative cardiology services, infertility, emergency medicine, and spinal surgery. Columbia Audubon Hospital in Louisville has the busiest emergency room in the state. Columbia currently employs nearly 8,500 people in the Bluegrass State.

Division of Disability Determinations #430
102 Athletic Drive, First City Complex
PO Box 1000
Frankfort, KY 40602
(800) 928-8050, ext 4024

Obtaining good medical evidence and maintaining an adequate panel of consulting physicians is vital to the functioning of the Social Security Disability program. Representatives of the Kentucky Division of Disability Determinations Services (DDS) exhibit at professional medical conventions at local and state levels to promote understanding of the medical needs of the disability program. Through understanding, the medical community and DDS can work together to serve the needs of Kentucky's disabled.

Dodson Group #333
9201 State Line
Kansas City, MO 64114
(800) 825-3760

Eli Lilly and Co #434
Lilly Corporate Center, DC 1843
Indianapolis, IN 46285
(317) 276-2309

Floyd Memorial Hosp & Health Svcs #326
1850 State Street
New Albany, IN 47150
(812) 949-5645

Fujisawa USA, Inc #103
Three Parkway North
Deerfield, IL 60015
(847) 317-8880

Greentree Apply Systems, Inc #419
157 Prosperous Place #1A
Lexington, KY 40509
(606) 263-2959

Grogans Healthcare Supply Inc #224
1016 S Broadway
Lexington, KY 40504
(606) 254-6661
Join us in Grogan's booth for a look at office lab equipment and surgical instruments.

Health Care Excel, Inc #435

9502 Williamsburg Plaza, Suite 102
Louisville, KY 40223
(502) 339-7442

Health Care Excel (HCE) is the Medicare Peer Review Organization (PRO) for Kentucky. HCE will be doing very little case review in the future. Instead it will be collaborating with hospitals, physicians, and other health care providers and communities in health care quality improvement projects.

This Technical Exhibit will present a variety of quality improvement projects in which HCE is or has been active in Kentucky.

HealthFind Com #121

by Mo' Better Marketing
516 W Main St #4
Louisville, KY 40202
(502) 580-1570

Infectious Disease Control, Inc #401A

2711 Rodman St
Louisville, KY 40208
(502) 635-1854

Infectious Disease Control, Inc is a full service Medical Waste Disposal Company, servicing the entire state of Kentucky. IDC, Inc also offers your facility an In-Service on compliance with the new OSHA Bloodborne Pathogen Standard and a full line of Sharps Containers. For more information, call Infectious Disease Control, Inc, Lyndell L. Shepherd, 2711 Rodman St, Louisville, KY 40208. (502) 635-1854.

Jewish Hospital #100A

100 East Liberty St, Suite 300
Louisville, KY 40202
(502) 568-6655

In support of the medical staff of Jewish Hospital and Jewish Hospital HealthCare Services' network physicians, the Physician/Hospital Development Department offers comprehensive programs to assist the private practice physician in building a practice and managing it effectively. Strategic planning resources are available to enhance the physician's practice in the community.

Kentucky Air National Guard #303

1019 Old Grade Lane
Louisville, KY 40213-2623
(502) 364-9424

Kentucky Army National Guard #311

Boone National Guard Center
Frankfort, Kentucky 40601
(888) KY Guard

Today, the mission of the Army National Guard is a dual one, state and federal. It offers physicians and other medical professionals the opportunity to serve their state and nation. Many doctors train to be flight surgeons, battalion surgeons, and general medical officers, which give opportunities that no other part-time career can. You receive good pay, benefits; \$30,000 bonus and \$20,000 student loan repayment available,

retirement, and other valuable training that will enhance your career. The Kentucky Army National Guard Recruiting Team will be available to answer any questions and give out literature. Stop in and see us or give us a call at 1-888-KY GUARD (1-888-594-8273) or 1-502-564-8575.

Kentucky Eagle Energy Co, Inc #423

530 W Main St
Louisville, KY 40202
(502) 585-3800

Kentucky Eagle Energy Co, Inc ("EAGLE") was formed in Kentucky in 1995 as a corporation under Kentucky law for the purpose of promoting the drilling and completion of oil and gas wells and for the operation of such wells as are deemed commercially feasible for the production of oil or gas and to act as the managing general partner of the drilling program it forms.

Kentucky Hospital Insurance Agency #421

1302 Clear Spring Trace
Louisville, KY 40223
(502) 426-6220

Kentucky Hospital Insurance Agency provides a full range of Property and Casualty and Life and Health insurance products and services to health care providers, including Kentucky Hospital Service Corporation's three trusts: Kentucky Hospital Association Trust (KHAT) for professional liability; Compensation Hospital Association Trust (C-HAT) for workers' compensation; and Kentucky Hospital Employee Health Benefit Trust (KHEHBT), dba TrustCare for health benefits.

Kentucky Medical Insurance Company and KMA Insurance Agency #218

303 North Hurstbourne Parkway
Louisville, KY 40223
(502) 339-5700

Kentucky Medical Insurance Company (KMIC) is Kentucky's largest medical liability company. KMIC is rated A-(Excellent) by A.M. Best and endorsed by the Kentucky Medical Association. In addition to offering an unconditional consent to settle clause, KMIC has a superb record of winning claims on behalf of Kentucky doctors.

The KMA Insurance Agency offers a complete line of personal and business insurance. The agency also markets the endorsed KMA group health plan.

Kentucky Organ Donor Affiliates (KODA) #111

106 E Broadway
Louisville, KY 40202
(502) 581-9511 or 1-800-525-3456

Kentucky Organ Donor Affiliates is the federally certified non-profit organ procurement organization, whose service area included 112 hospitals. KODA provides training for hospital staff on organ and tissue donation and transplantation, ensuring that hospitals establish policies and procedures on donation protocol, notify KODA of potential donors, and offer the option of donation to families, as required by federal and state law.

The Kentucky Spine Institute

135 East Maxwell Street, Suite 208
Lexington, KY 40508
(606) 255-3758

The Kentucky Spine Institute is affiliated with Columbia Hospital Lexington and was established to provide premier evaluation, surgical, psychological, and rehabilitation services for individuals who suffer with various disorders of the back and spine. Our goal is to assist individuals who suffer with back disorders in returning to a normal, productive lifestyle.

Key Pharmaceuticals

2000 Galloping Hill Rd
Kenilworth, NJ 07033
(908) 298-4000

Exhibiting Key Pharmaceuticals line of cardiovascular and respiratory medications; IMDUR, a once-a-day oral extended release formulation of isosorbide mononitrate available in 30 mg, 60 mg, and 120 mg tablets; CLARITIN, an antihistamine for the relief of nasal and non-nasal symptoms of seasonal allergic rhinitis; CLARITIN D, an antihistamine decongestant for the relief of seasonal allergic rhinitis; and VANCERIL, an oral inhaled steroid for the treatment of chronic asthma.

Lexington Diagnostic Center

1725 Harrodsburg Road, Suite L
Lexington, KY 40504
(606) 278-7226

Lexington Diagnostic Center and Kentucky Regional MRI Centers are conveniently located in Lexington, Danville and Frankfort. Our exhibit features examples of two types of MRI scanners: an open, non-claustrophobic scanner and a super conducting, high-field scanner with the largest scan gantry in the Bluegrass area. With 4 locations, same day scheduling is usually possible, expediting patient care.

Lincoln Trail Behavioral Health System

3909 S Wilson Road
Radcliff, KY 40160
(502) 351-9444

At Lincoln Trail Behavioral Health System, our goal is to provide help for today and hope for a bright tomorrow by giving each patient the skills and support to achieve lasting recovery. To meet the unique needs of the adults and adolescents who come to us, we offer a variety of inpatient and outpatient programs for emotional problems and chemical dependencies. Our teams of professionals work closely with our patients' physicians to provide balanced care for the whole person.

Mark Kidd Studios

125 Clay Avenue
Lexington, KY 40502
(606) 255-8088

Mead Johnson Nutritionals

2400 W Lloyd Expressway
Evansville, IN 47721
(812) 429-5000

We cordially invite you to visit our exhibit to meet our repre-

sentatives who welcome the opportunity to discuss products and services of interest to you. Featured will be: Boost, Enfamil, Lactofree, Next Step, Nutramigen, ProSobee, Sustacal.

The Medical Protective Company

5814 Reed Road
Fort Wayne, IN 46835
(219) 486-0473

The Medical Protective Company has been defending doctors against the allegations of malpractice since 1899. The largest insurer of doctors in the country, The Medical Protective Company offers both occurrence and claims-made coverage and specializes in professional liability insurance for the health care community.

Medical Society Professional Services

101 West Chestnut Street
Louisville, KY 40202-1881
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Employment Services offering temporary to permanent positions. Practice Services offering Educational Courses & Consulting Services, full practice assessment, problem-solving, personnel assessment (Myers-Briggs), in-house training, customized problem resolution and implementation. INTRA. Micrographics.

Merck & Co, Inc

321 Comanche Rd
Shelbyville, KY 40065
(502) 633-4317

Money Concepts Financial Planning Center

312 Whittington Parkway, Ste 120
Louisville KY 40222
(502) 429-0196

Money Concepts is a full service financial planning firm. We are an independent firm which enables us to be totally objective. Retirement planning, estate planning, and planning for business continuation are of vital concern to physicians. We will have materials available to address these areas. In keeping with a high degree of professionalism, we will not have available any sales material. It will be our expressed purpose to respond to questions providing educational material when requested.

Norton Hospital Cancer Treatment

200 East Chestnut Street
Louisville, KY 40202
(502) 629-8000

Information and materials on some of the most advanced treatments available for a variety of cancers will be featured, including photodynamic therapy, genetic testing and counseling, cryosurgery and many others.

Norton Psychiatric Clinic

200 E Chestnut Street
Louisville, KY 40232
(502) 629-3743

Olympus America

1805 Crossgate
Louisville, KY 40222
(502) 426-9370

#210

The Pain Institute

9115 Leesgate Road, Suite C
Louisville, KY 40222
(502) 423-7246

#412

Founded in 1992, The Pain Institute was the first physician group in this area comprised of Fellowship trained Anesthesiologists who are experts in the diagnosis and treatment of pain disorders. Our goal has been and continues to be to provide safe, successful and cost effective treatment modalities using the latest technologies so that our patients can return to pain-free, normal productive lives.

The Pain Institute provides a comprehensive, multi-disciplinary approach to the treatment of acute and chronic pain syndromes on both an inpatient and outpatient basis. The Pain Institute physicians treat many pain disorders including: cancer, head and neck pain, back pain, headaches, reflex sympathetic dystrophy, causalgia, neuralgia (including shingles), rib fracture pain, phantom limb pain, facial pain, musculoskeletal pain, arthritis (joint pain), or any other type of constant pain.

The Pain Institute serves the following areas: Louisville, Shelbyville, Madison, Floyd County, and Charlestown. For more information about The Pain Institute, call us today in Louisville at (502) 423-7246, in Kentucky at (800) 599-7246, or in Indiana at (800) 788-7549.

Pfizer Labs

14402 Willow Grove Circle
Louisville, KY 40245
(502) 254-1170

#431

The PIE Mutual Insurance Company

9300 Shelbyville Road, Suite 1001
Louisville, KY 40222-5183
(502) 339-7431

#416

The PIE Mutual Insurance Company of Cleveland, Ohio offers Kentucky physicians the advantages of an insurance program that has made it the leading professional liability carrier in Ohio. Owned and controlled by policyholders, the PIE is a non-profit company whose innovative program features claims handling by a specialty law firm, physician participation in all areas of operations including peer review of all applicants, and rate stability that rewards loss-free physicians with scheduled premium reductions.

Pikeville Methodist Hospital

911 S Bypass Road
Pikeville, KY 41501
(606) 437-3985

#203

Procter & Gamble

10200 Alliance Rd
Cincinnati, OH 45242-4716
(513) 626-6515

#100

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about Asacol® (mesalamine) delayed-release tablets, Droned® (etidronate disodium), Macrobid® (nitrofurantion monohydrate/macrocrystals), Ziac® (bisoprolol fumarate-hydrochlorothiazide), and Metamucil® with an all-natural active ingredient, psyllium.

RCFA Healthcare Management Services

#131

9648 Kingston Pike, Suite 8
Knoxville, TN 37922
(800) 635-4040

A broadbased group of healthcare management specialists dedicated to the improvement of efficient healthcare business practices. Our clients include physicians, hospitals, and clinics.

Ransdell Surgical, Inc

#227

752 Barret Avenue
Louisville, KY 40204
(502) 584-6311

Rexall Showcase International

#327

1520 Hawkshead Ln
Louisville, KY 40220
(502) 499-9909

This exhibit features the newest and fastest growing division of Rexall; Rexall Showcase International R.S.I. distributes non-prescription preventative health care products. These products address, in a proactive fashion, such wide-ranging health issues as cardiovascular health stabilization of blood sugars, skin therapy, and nutritional supplementation.

Roerig, a division of Pfizer

#334

914 Bridgecreek Rd
Louisville, KY 40245
(502) 254-5871

Royal Bank of Canada

#433

c/o Fox Investment Management, Inc
9911 Shelbyville Road, #105
Louisville, KY 40223
(502) 327-7830

Royal Bank of Canada — Your International Trustee. Properly structured and implemented, an international (off-shore) trust can: enhance wealth protection, increase financial privacy, enhance investment returns through global exposure. Through the Royal Bank of Canada, your trust can be registered offshore, while your trust assets can be at your control in domestic vehicles, ie, mutual funds, brokerage accounts, etc. For more information please contact Jerry Devins, at 9911 Shelbyville Road, #105, Louisville, KY 40223, (502) 327-7830 or (800) 356-5467.

Saint Joseph Hospital

#426

One Saint Joseph Dr
Lexington, KY 40504
(606) 278-3436

Saint Joseph Hospital is a 468-bed tertiary referral medical complex serving central and eastern Kentucky. Saint Joseph is Lexington's oldest hospital, established in 1877 by the Sis-

ters of Charity of Nazareth. Today, Saint Joseph is an affiliate of the Sisters of Charity of Nazareth Health System.

Clayton L Scroggins Associates #427

200 Northland Blvd
Cincinnati, OH 45246
(513) 771-7070

For more than 50 years, Scroggins Associates has provided financial and practice management consulting services exclusively to physicians. Impartial counsel in a professional, comprehensive, and confidential manner on a fee-for-service basis. Editorial consultants to *Medical Economics* and *Physician's Management* magazines. Services throughout Kentucky, Ohio, and Indiana.

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SEL, Inc is in the unique legal position to provide management of employees of medical practices in order to reduce employee liabilities, provide competitive benefits to employees at reduced rates, increase retirement futures of practitioners, allow doctors to practice medicine and to allow office managers to perform duties directly related to profit margins.

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Louisville, KY 40220-4010
(502) 491-3484

SmithKline Beecham Pharmaceuticals #233

4445 Lake Forest Dr, Suite 490
Cincinnati, OH 45242
(800) 528-6592

Southeastern Data Systems Inc #437

1324 Centerpoint Blvd
Knoxville, TN 37931
(423) 539-0011

Southeastern Data Systems Inc is a turnkey provider of practice information systems. Representing both the VERSYSS MENDS-ICF and The Medical Manager, a solution is available for any need. With extensive experience with MSOs and practices of all sizes, SDS can present a solution for all of an organization's information needs. Southeastern Data Systems has offices in Lexington, Kentucky and Knoxville, Tennessee.

Southern Medical Association #304

35 Lakeshore Drive
Birmingham, AL 35209
(800) 423-4992

Sterling Healthcare Group #117

405 Madison Avenue #210
Toledo, OH 43604
(419) 249-6500

United Leasing, Inc #125

4360 Brownsboro Road, #105
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800-866-1333

United Leasing is a full service leasing company endorsed by the Kentucky Medical Association. Over the past 18 years we have provided equipment and vehicle leasing services to start up physicians as well as large healthcare facilities.

University of Kentucky Hospital #400

800 Rose Street
Lexington, KY 40536-0084
(606) 323-5000

The physicians practicing at UK Hospital and Kentucky Clinic are committed to meeting the consultation and referral needs of physicians throughout the commonwealth. Comprehensive services include cancer and cardiac specialties, neurosciences, obstetrics and gynecology, and pediatrics. The 473-bed hospital offers Level I trauma care, organ transplantation, neonatal intensive care, a children's hospital, magnetic resonance imaging, and multidisciplinary programs. Visit our booth to learn more about our physician access service including the UK-MDs physician-to-physician 800 number.

Vanderbilt University Medical Center #113

Physician Liaison Program, 405 Oxford House
Nashville, TN 37232-4335
(615) 936-0305

The intent of the Physician Liaison Program is to address the concerns of physicians referring to Vanderbilt University Medical Center and to assist them in arranging referrals, utilizing the Medical Center resources, obtaining consultation, receiving follow-up reports, and facilitating education through library access and faculty presentations. The staff currently visit physicians in Western Kentucky and bordering counties.

Visiting Nurse Association #413

101 W Chestnut St
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(502) 584-2456

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Wyeth-Ayerst Laboratories #212

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Wyeth-Ayerst welcomes the opportunity to continue their longstanding association with the Kentucky Medical Association through participation in your exhibit program. Our professional representatives will welcome the opportunity to visit with you and discuss any inquiries you may have concerning our products.

WE DON'T WANT TO MISS YOU!!

SET ASIDE THURSDAY NIGHT
TO JOIN YOUR FELLOW PHYSICIANS AT

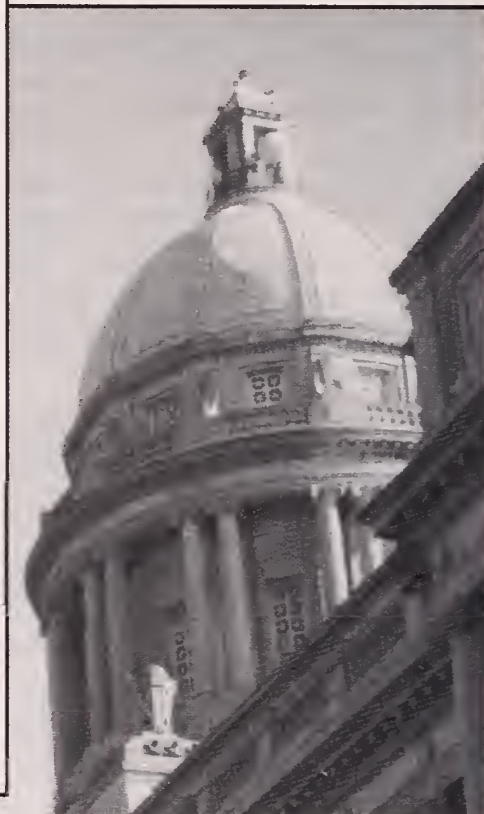
THE 34TH ANNUAL KEMPAC SEMINAR-DINNER

DATE: THURSDAY, September 26, 1996

TIME: 6:00 PM EDT — Reception
7:00 PM EDT — Dinner
Program to Follow

PLACE: Regency Ballroom
Hyatt Regency Hotel
Louisville, Kentucky

KEMPAC



FEATURED SPEAKER —

P. John Seward, MD

EVP, American Medical Association



TICKETS ARE NOW AVAILABLE!

They may be purchased from the KEMPAC Headquarters Office for \$30.00 each.

PLEASE NOTE — THE KEMPAC BANQUET will be on THURSDAY NIGHT!!

Make your plans now, and watch for more information.

C. Kenneth Peters, MD Nominated for KMA President-Elect

C. Kenneth Peters, MD, has been nominated by the Jefferson County Medical Society for the office of President-Elect of the Kentucky Medical Association.

A family physician practicing in Jeffersontown, Dr Peters is a Past President of the Jefferson County Medical Society and served KMA as Vice Speaker of the House from 1989 until 1994, when he was elected Speaker. He has also served as KEMPAC Chair, on the State Legislative Committee for 18 years, and as a KMA Delegate for 21 years.

He is a Charter Fellow of the American Academy of Family Practice and a member of the National Association of Occupational Physicians.

Dr Peters' commitments include community and civic affairs. He is a Past President of the Jeffersontown Rotary Club; member, Wesley Manor Retirement Center Board; member, Board of Pension and Health Benefits, Kentucky Conference, United Methodist Church; and has been team physician for Jeffersontown High School for 25 years.

A native Kentuckian, Dr Peters received an undergraduate degree from Kentucky Wesleyan College in 1957 and a medical degree from the University of Louisville School of Medicine in 1960. Following a rotating internship at St. Joseph Infirmary in Louisville, Dr Peters served as a US Navy physician in 1961-63 before establishing a family practice in Jeffersontown in 1963.

Dr Peters and his wife Rhoda have three children and two grandchildren.



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These are just some of the professions represented in our 1200-strong membership association, the Council of Biology Editors (CBE). Since the society was founded in 1957, biology and biology editing have undergone profound change. CBE's name has remained the same, but the diversity of member interests represented, as well as the scope of CBE's professional activities have changed dramatically.

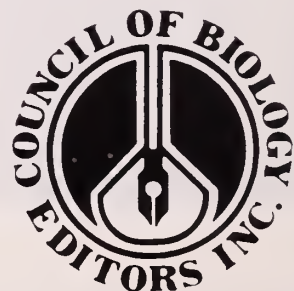
Here are five good reasons to join CBE Now:

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2. Member discount for Annual Meeting, held at great locations, such as Portland, Oregon; Philadelphia, Pennsylvania; and Salt Lake City, Utah. Current topics of concern to all members.
3. *CBE Views*. News and more in the bimonthly newsletter of the editing community.
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60 Revere Drive, Suite 500
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American Medical Association

Physicians dedicated to the health of America



P. John Seward, MD

The AMA's new EVP talks about his vision for the future.

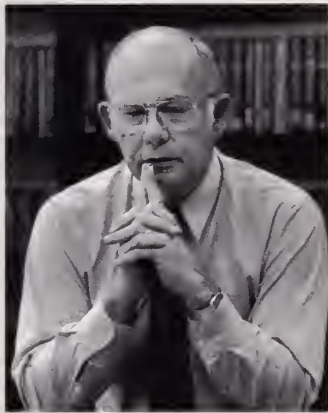


Photo by: Ted Grudzinski

What is your vision for the AMA?

To continue to reinforce our role as the primary national advocate for patients and physicians. In the most fundamental way, that is what medicine is all about. And the AMA can act on behalf of millions of patients. We continue in a good position to do this. We are financially secure and programmatically sound. We are strongly positioned as medicine's leader, and I see us continuing in that role.

How has your background prepared you for your current role as EVP?

I was a practicing doctor, with all the joys, problems, hassles, and tears that practicing medicine brings. I've also been the manager of a number of successful business enterprises

and a longtime public official. All of this and my service as member and chair of the AMA have given me enormous experience and perspective for assuming this new role.

Some physicians are reluctant to join the AMA because they don't believe it represents their interests. What will you do about that?

The AMA currently represents physicians' interests. We have represented physicians in Washington on issues of health system reform, Medicare and professional liability, we have led the charge in public health issues such as domestic violence and tobacco, and we are currently evaluating the Federation and how it can better serve the needs of physicians and their patients. If physicians don't believe we are representing their interests, then we have to look at how we are delivering our message. We need to articulate and communicate the value of membership in a better way.

More and more women and minorities are becoming physicians. What is their incentive to join the AMA?

These are physicians whose talents and dedication will

make health care better for all of us. Their incentive to join is representation and a chance to be an active participant in the changes in medicine as we prepare for the 21st century. The AMA has more female physician members than any other medical professional organization. We have a woman chair, Nancy Dickey, MD, for the first time in AMA history. We have Palma Formica, MD, and Regina Benjamin, MD, on the Board. We are seeing an increase in membership among minorities and international medical graduates because the AMA is seen as a solution to the hassles that they are facing.

The Federation study suggests changes in representation from state, county, and specialty societies. Will these changes significantly affect membership?

The AMA is a dynamic organization. We have been changing for years. The Federation study is just part of that change. The purpose of the Federation study is to give practicing physicians input in

how their societies make policy so that they do not feel shut out. I believe that membership will increase as a result of the study.

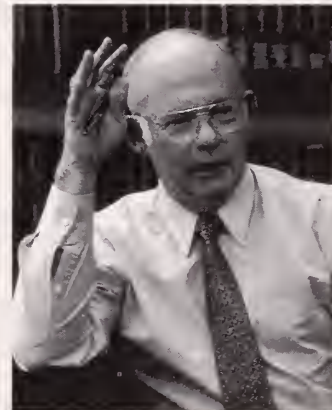
How will the AMA help doctors educate patients about changes in Medicare and Medicaid?

We will work with the media – sending our Board members to editorial boards and radio and TV stations across the country to broadcast our message. We will provide members with updates on all our Medicare activities as we implement them. As we have always done, we will listen to physician input about our policies and work with

America's physicians to bring about the best in health care for their patients.

Will the AMA continue public education and awareness programs on tobacco and domestic violence and other public health activities?

Definitely. Public education and public health have been



major AMA activities since our founding 150 years ago. As a Florida newspaper editorial said, maybe we don't really need a US Surgeon General as long as the AMA is around. The AMA is a recognized voice in public health issues and we take that responsibility very seriously.

How will the AMA help physicians gain more control over their careers during this time of change in physician's practice environments?

By continuing to inform physicians about our actions in Washington, about the environment in which they practice and about the best ways in which they can take control of their medical practice.

What are the AMA's 1996 legislative and political goals?

We still will be concerned with the issues we pursued in 1995. Last year was very busy, legislatively. We staked out our territory and stuck to it: Medicare, liability reform, doing away with hassles like Stark I and Stark II, CLIA and patient protections. We made tremendous headway. That agenda is still as cogent for 1996 as it was for 1995. If anything, the need to accomplish it is even higher. Just getting close doesn't excite me

much. Now we have to say - "we can do it!"

You were the elected county coroner for 23 years. How did that prepare you for AMA leadership?

An old friend of mine taught me that good politics is good service, and good service is good politics. You had to earn their trust every day. It

humbled me. It taught me to keep an open mind. Any time I jumped to conclusions, I was absolutely wrong. Team work is very important; you can't do it alone. I look at this job the same way. An

EVP isn't supposed to be a hero. If anything, I would classify myself as a "designer" of bringing people together, helping inspire our team to do a better job.

How do you see the practice of medicine changing?

Medicine in some ways hasn't changed at all. It's still about providing the best care to individual patients. In other ways, it's changing hugely in what we can do for those patients. The cost of health care will continue to be a major issue. Anytime you upgrade, you create new concerns, specifically ethical ones. Will our ethics be able to keep up with how we apply technology to our practices? As professionals, we have to be

leaders in this because it's our duty. The AMA has to help our physicians say, yes, we are still on course, but we are also advancing.

How will the AMA work to overcome the loss of collegiality and unite physicians in the future?

I'm an eternal optimist. Is collegiality irretrievably lost? I don't think so. As physicians, we all have so much in common - our devotion to medicine and to our patients, and the problems that affect us all in the practice of medicine. I'm confident that we have the motivation and the desire to work together. When you talk to physicians who are saddened, anxious and depressed, it doesn't matter what type of health care delivery system

they're practicing in, they are still physicians. This is where the AMA can be the catalyst to redefine who and what we are. To show we all need to work together. This is a legacy issue. I want to make sure we leave the profession better off than what we found it. This is how I want to be measured.

How will your role differ from that of your predecessors?

I'm different and the times are different. The information age has brought everybody closer. When somebody sneezes in Seoul, Korea, it affects me in

Rockford, Illinois. It's the same medicine. The AMA must continue to be better focused, more receptive, more efficient. We do not have the luxury of contemplation and inaction. We have to be faster on our feet.

What about Medicare reform?

The AMA is committed to transforming Medicare. We'll stay the course. The proposals we gave to Congress are still on the agenda. Patient choice. Quality of care. Physician-sponsored networks. Patient protection, medical liability, reform, relief from Stark I and Stark II, CLIA.

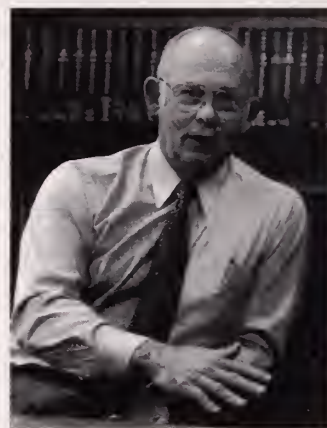
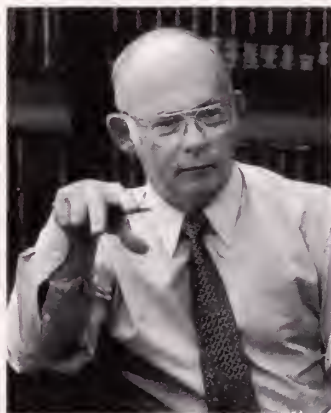
What about Medicaid Reform?

We want to make sure this vulnerable group receives

adequate and appropriate care. They're patients. They're also family, neighbors, and friends. Standards have to be maintained to make sure that they do obtain care, whether it's by "block

grants" or some other mechanism. We also have to consider long term care. On this and so many other critical issues, the AMA has to be a watchdog. We have to help define the road the country needs to take if all our patients are to get the care they need. ♦

Interview by Linda Stepanich.



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Somerset (606) 678-9164

National HIV Telephone Consultation Service

800-933-3413

This toll-free "Warmline" telephone consultation service, based at San Francisco General Hospital, is available to physicians and other health care providers with HIV-related clinical management questions.

Calls are answered by a team of HIV experts consisting of physicians, nurse practitioners, and clinical pharmacists.

Consultants are on duty between 10:30 am and 8:00 pm EST. Calls at other times are recorded and returned as soon as possible.

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How to protect yourself against stockbroker fraud and mismanagement

- Ignore all cold calls from stock brokers.
- Investigate a broker thoroughly before signing a customer agreement.
- Never buy or sell under pressure from your broker.
- Insist on approval of all trades.
- If you cannot completely understand the monthly account statement from your brokerage firm and all of the agreements you are asked to sign, consult your attorney, accountant, or an independent investment advisor.
- Never sign any agreement that contains a pre-dispute arbitration provision.
- Carefully review all information about your investments, especially limited partnerships. When in doubt, consult your attorney or accountant.
- Be cautious about signing margin agreements.
- Insist on annual, or semi-annual, reviews of your account with your broker.

These are but some of our suggestions for protecting yourself against such stockbroker abuses as unauthorized trading, fraud, churning, and misrepresentation.

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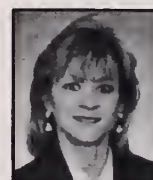
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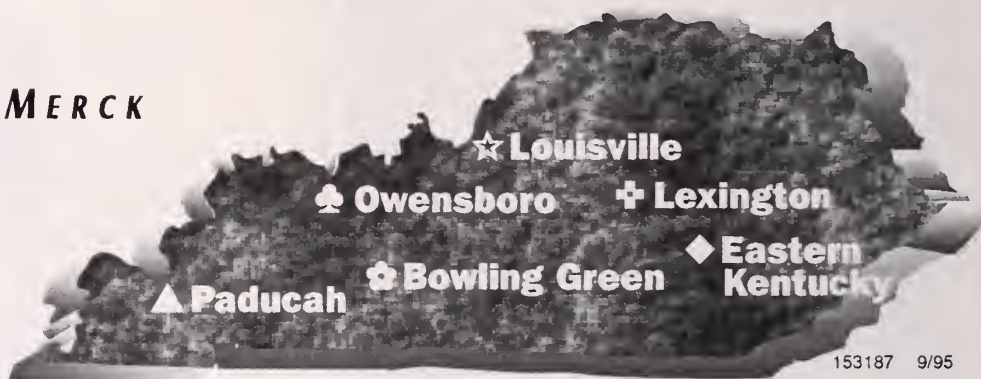


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“It’s time to end the discrimination in health insurance.”

The House and the Senate are taking important strides toward seeing that more people maintain their access to health care. Congress is poised to pass long-needed laws making health insurance portable and ending exclusions because of pre-existing medical conditions. But that alone will not end the discrimination in health insurance. Medical Savings Accounts and coverage for people with mental illnesses are two more steps Congress should take to make sure millions more Americans get the care that today they are denied.

“Everybody—including the self-employed—should have equal ability to decide how to spend their health care dollars.”

MSAs are a choice millions want but are denied. National surveys report that 43 percent of all workers would consider switching to an MSA if they could. Today, only 2,000 employers offer them to their employees, because under current law, they don’t qualify for the same beneficial tax treatment as other forms of health insurance. So far, 15 states have enacted MSA legislation. It makes sense to make MSAs available to the people who want them.

“People with mental illness should have the same access to care as people with other illnesses.”

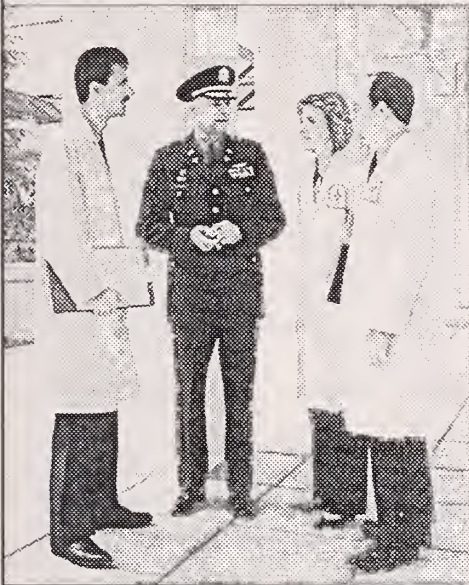
Anyone who has watched a family member or friend succumb to mental illness knows that it is just as real as other diseases. Legislation passed by the Senate requires insurance companies to put mental illness on an equal basis with other medical conditions. Parity will save the economy some \$2.2 billion a year in reduced absenteeism, higher productivity and lower health care costs.

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| Caritas Peace Center | 313 |
| Classified | 369 |
| Financial Architects, Inc | 367 |
| KY Medical Insurance Company, Inc ... | Cover II |
| Lexington Diagnostic Center | Cover IV |
| MP System 2000 | 369 |

| | |
|------------------------------------------|-----------|
| Medical Protective Co | 320 |
| Charles C. Mihalek, PSC | 367 |
| National HIV Consultation Service | 367 |
| National Insurance Agency, Inc | 318 |
| Prime Care Center | 368 |
| Republic Bank | 317 |
| University Radiological Associates | Cover III |
| US Army Reserve | 371 |

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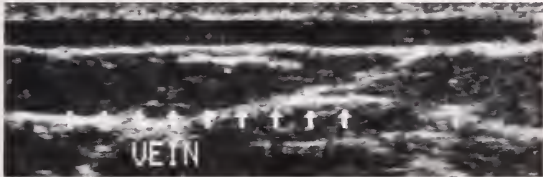
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This month, **Catherine Brandon, M.D.**, of the Brown Cancer Center, a fellowship-trained interventional breast radiologist, presents the following case:



Ultrasound of the left breast showing a thrombosed superficial vein.



Normal ultrasound of an adjacent vein.

A 41-year old woman presents with a painful ridge in the upper inner quadrant of the left breast. Mammography demonstrated only fatty tissue. A vein with internal echoes on ultrasound corresponds exactly to the painful ridge by physical examination. Superficial transient phlebitis of the breast is often unrecognized without diagnostic ultrasound. Mondor's Disease, lateral thoracic vein phlebitis progressing to a fixed fibrous cord, is better known. The lesion resolved without complication.

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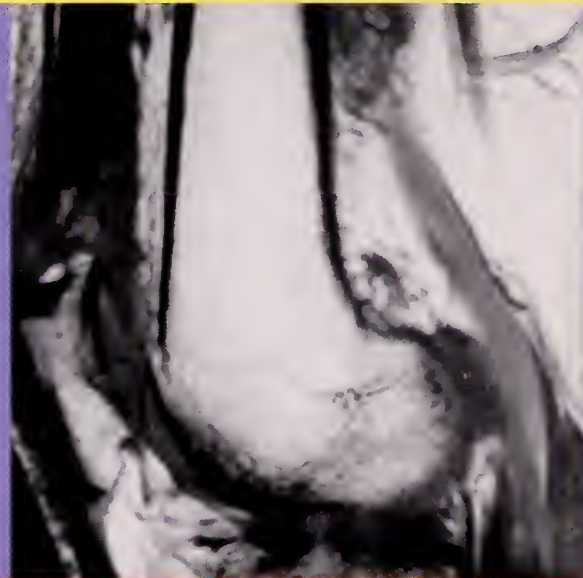


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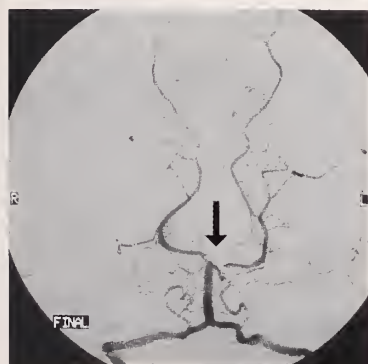
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This month, **Gregory C. Postel, M.D.**, a senior member of the American Society of Neuroradiology, presents the following case:



Pre-Embolization



Post-Embolization

The patient initially presented with a ruptured anterior communicating artery aneurysm and was found to have a second aneurysm at the tip of the basilar artery. The ruptured aneurysm was successfully clipped, but two surgical attempts failed to treat the basilar tip aneurysm. Via a right common femoral artery approach, a small catheter was placed directly into the aneurysm and multiple metal GDC coils were deployed. The coils obliterated the aneurysm lumen and post embolization arteriography demonstrated no flow within the aneurysm. The patient tolerated the procedure well and was discharged two days after the procedure.

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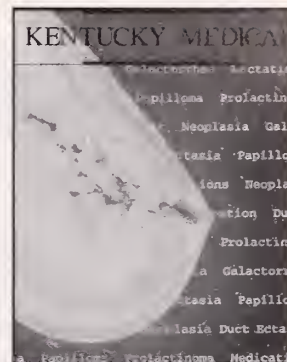
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VOLUME 94, NUMBER 9

SEPTEMBER 1996

| | | |
|------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| COVER STORY | The Clinical Challenge of Nipple Discharge <i>Scott W. Taber, MD</i> | 387 |
| SCIENTIFIC | Hot Tub Legionellosis <i>Arthur Tolentino, MD; Sunket Ahkee, MD; Julio Ramirez, MD</i> | 393 |
| SPECIAL ARTICLE | Occupational Fatalities in Kentucky — 1994 <i>Tim W. Struttman, MSPH; Elyn Moon-Hampton, MA; Amy Scheerer, BS; Susan H. Pollack, MD; Carl Spurlock, PhD</i> | 395 |
| EDITORIALS | The Bells Are Ringing <i>A. Evan Overstreet, MD, Editor</i> | 402 |
| | What's in a Word? <i>Wallace V. Mann, Jr, DMD</i> | 403 |
| ASSOCIATION | Monitoring Medicine | 383 |
| | KMA Headquarters Office Moves to New Site in October | 408 |
| | Daniel W. Varga, MD, JCMS President | 409 |
| | News | 409 |
| DEPARTMENTS | President's Page | 381 |
| | Advertisers' Guide | 416 |
| | Alliance Page | 405 |
| | Classifieds | 414 |
| | Continuing Education | 413 |
| | Information for Authors | 400 |



COVER: "Is my nipple discharge malignant?" is the question being asked increasingly at health care providers in all specialties, as the public's awareness of breast cancer is heightened. This article describes the types of nipple discharge, specific cancer risk factors associated with nipple discharge, medical and surgical galactarrhea, and various treatment options. Artwork by Lee Wade of Eminence, KY. (With permission to reprint from Dr Scott Taber.)

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Team Effort = Success

Your medical association has had a successful year. We have been able to accomplish the goals set out for us by the House of Delegates in 1995. Some of these tasks are not completed, but they are all well under way. We have been able to establish a working relationship with the Administration — something we have not had in recent years. From our first meeting in January of this year, Governor Patton has done everything he said he would, and I truly feel he is as interested in working with us as we are with him. Much of the credit of this goes to one of our own, Lieutenant Governor Steve Henry, who has been very receptive to our concerns and responsible for much of the progress we have made.

This must be only the beginning of the active participation of all physicians in the legislative process. We need more physician legislators. Senators Crase and Kafoglis and Representatives DeWeese and Fletcher are to be commended for the hard work they do and encouraged to continue their political efforts. We must all support the candidate of our choice. Jim Crase gave an interesting talk one night; he suggested that each physician budget a thousand dollars a year for contributions to various political candidates of their choice. I support him in this and would encourage everyone to consider it.

The only really sour note this year has been Unisys. I believe it has

frustrated the Administration almost as much as it has physicians. Hopefully, the worst of it is over, and they are about to get caught up with back payments; but it is difficult to understand in this day of computer technology why it has taken so long to straighten out Medicaid reimbursement.

It is with sadness that we accept Bob Cox's resignation. Our growth under his leadership in size, effectiveness, and financial stability has been amazing, and he will be sorely missed by this Association. I hope that each and everyone of you can find time to talk to Bob or drop him a note wishing him well.

On a personal note, I want to thank you for giving me the opportunity to serve you this year. Joyce and I have been all over the state and met so many fine people. Our visits to other state meetings have brought friends to us that we would never have had otherwise.

I want to thank the officers of the Association, the trustees, and other members of the Board for the support they have given me this year. The success we have had has been a team effort and everyone has contributed.

Our staff has done its usual fine job. You hear this every year, but it is hard to appreciate how good they are until you are able to work with them on a daily basis. You know that things are going to be done on time and done properly, and that the advice



Danny M. Clark, MD

"The success we have had has been a team effort and everyone has contributed."

they give you will keep you out of a great deal of trouble.

I appreciate the support I have received from the Pulaski County Medical Society and Alliance, and particularly want to thank Drs Ruben Nazario, Dennis Faulkner, and Bert Gonzalez for the untold hours of coverage they have given me in the past year as well as previous years.

It has been a true pleasure and labor of love, and Joyce and I are very grateful that we have had this opportunity.

Danny M. Clark, MD
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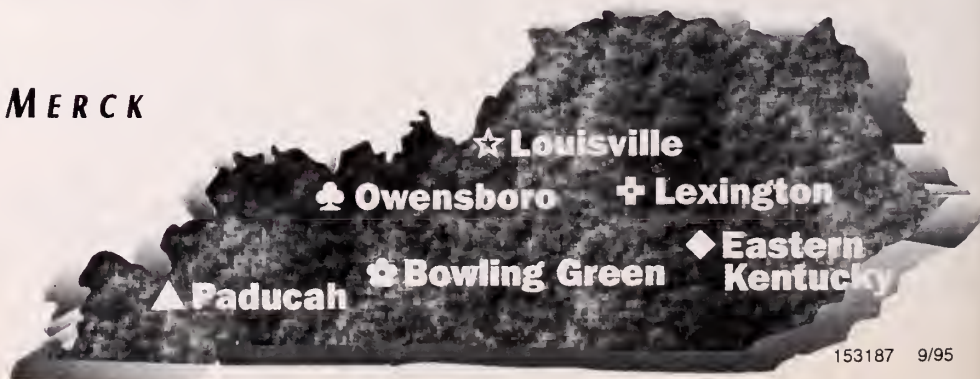


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MONITORING MEDICINE

NEWS FOR KENTUCKY PHYSICIANS

The KMA Board of Trustees met on August 14 & 15 in Louisville. The primary purpose of the August Board Meeting is to review final reports of KMA standing and ad hoc committees and consider resolutions for the 1996 House of Delegates.

Special guests and speakers at the Board meeting included Lt Governor Stephen L. Henry, MD; Commissioner of Insurance George Nichols; Director of Medicaid Services Larry McCarthy; and UNISYS officials. Lt Governor Henry focused on the continuing problem with UNISYS and the implementation of SB 343. Henry reaffirmed legislative action by clearly pointing out that practice parameters would no longer be developed or utilized in the Medicaid program. A separate law adopted in 1994 permits the Labor Department to develop and approve practice parameters under Workers' Compensation.

Commissioner of Insurance George Nichols explained the hearing process that is required by SB 343 before health insurance premiums can increase beyond a specific percentage. Board members expressed concern with the continued delay in considering premium requests pointing out that some companies have frozen or applied reimbursement cuts to providers other than physicians. Several questions were directed to the Insurance Commissioner including:

1. Denial of 48-96 hour stays in the hospital for expectant mothers.

The Commissioner requested that the Department be notified immediately if an insurance company enforced the "24 Delivery" provision without physician/patient approval.

2. Questions relating to the Any Willing Provider law.

Commissioner Nichols informed the Board that the Insurance Department will enforce the literal interpretation of the Any Willing Provider law adopted in 1994 and reaffirmed by the General Assembly via SB 343. As a result of several questions, the Commissioner indicated that the AWP provision would

also apply to physician labs which meet defined criteria.

Medicaid Director Larry McCarthy commented on the Health Partnership Medicaid Managed Care program being developed on a regional basis. The program is part of a special waiver under Medicaid granted by HCFA during the Brereton Jones administration. According to the discussion by Board members, regional partnerships are expensive to develop and are primarily suited to Universities and large hospitals which have the capital and staff to adequately develop the programs in accordance with waiver restrictions.

Processing of medical claims continues to be a problem for physicians and the Patton administration. As you recall, the Jones administration replaced EDS with UNISYS one day before the Patton-Henry administration took command. According to UNISYS, their backlog has now been reduced to 90 days and they are working to reduce suspended and delayed claims. Additional staff has been brought on board. According to unconfirmed reports, the Patton administration is considering enforcing fine provisions and rewarding providers who have financially suffered from this ordeal. UNISYS agreed to work with a KMA appointed committee to assist in resolving problems related to delayed claims. The Lt Governor urged physicians to contact his office if they are having problems with UNISYS. The Lt Governor can be reached at (502) 564-2611.

Discussion ensued regarding the settlement of KMA's \$52 million lawsuit along with the agreement to add \$26 million back into Medicaid reimbursement. Director McCarthy was questioned intensely about RBRVS and Medicaid coding procedures. The Department has agreed to work with physicians on resolving these and other questions relating to the Medicaid RBRVS mechanisms.

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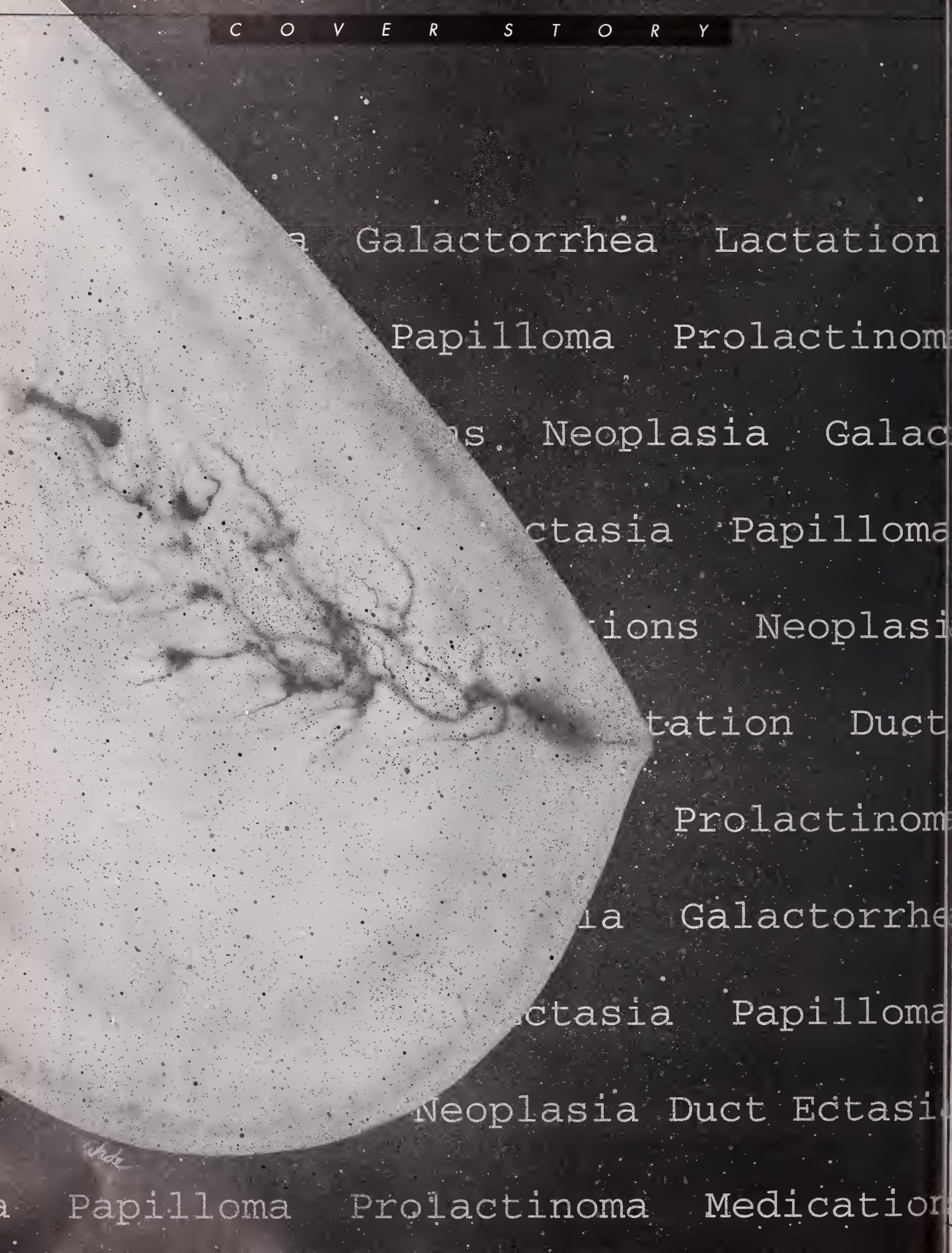
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The Clinical Challenge of Nipple Discharge

Scott W. Taber, MD

Nipple discharge is a complex diagnostic challenge for the clinician. Intraductal papillomas, pituitary adenomas, breast abscesses, anovulatory syndromes, breast trauma, infections, Paget's disease, and breast cancer all can manifest as nipple discharge. The diagnosis and treatment of this breast disorder requires a solid knowledge of anatomy, physiology, and endocrinology.

Medical school curricula and most residency training programs usually include training in the diagnosis and treatment of a breast mass or abnormal mammography findings, but only a small portion of the curricula and literature is devoted to the treatment of nipple discharge. However, with heightened public awareness of breast cancer, an increasing number of women are now asking their health care providers about nipple discharge.

In one large metropolitan series,¹ 10% of the patients studied experienced nipple discharge, while only 3% actually had an associated breast cancer. Leis and Cammarata² and Devitt³ also reported a 2% and 3% incidence of breast cancer in patients whose initial complaint was nipple discharge. The clinician therefore should be aware that the human breast is a complex organ comprised of multiple cell types, all of which are susceptible to carcinoma.

The human breast is made up of 15 to 20 terminal ducts lined with columnar epithelium. These ducts are arranged around the central nipple/areolar complex in a radial pattern, much like the spokes of a wagon wheel. Each duct serves as the collecting unit for the mammary gland acini, which are lined with columnar epithelium and supported by a basement membrane.^{4,5} The remainder of the breast is comprised of connective tissue stroma, specialized dense connective tissue bands called Cooper's ligaments, and fat cells.

In the male and female breast, the lactiferous ducts and sinuses are present at birth. This forms a rudimentary geography of the ductal system, which undergoes only minor alterations during

puberty. In the male breast, a slight enlargement occurs during the prepubertal and pubertal phases of maturation, but essentially the breast remains unchanged throughout life. The female breast, however, undergoes extensive proliferation of lobules and glandular elements during puberty. Lactiferous ducts and sinuses become larger in diameter and the mammary glands proliferate and enlarge.

The lactating breast represents the mammary glands and lobules at their maximal state of proliferation. Milk is produced by the cuboidal and columnar cells of the mammary glands. The lactiferous ducts and sinuses dilate to accommodate lactation. Components of breast milk are released by *apocrine* secretion from the mammary gland into the ductal system of the breast. Throughout pregnancy, increasing levels of estrogen and progesterone stimulate the proliferation of the mammary glands and lobules in preparation for nursing a newborn. A neurohormonal axis between the nipple/areolar complex, combined with the release of prolactin from the pituitary gland and adrenocorticoids from the adrenal gland, causes milk production to continue until an infant is weaned.⁶ Because the breast is sensitive to estrogen and progesterone, the mammary glands, lobules, lactiferous ducts, and the lactiferous sinuses enlarge and recede at the onset of ovulation and menstruation.

TYPES OF NIPPLE DISCHARGE

Nipple discharge is categorized as "pseudonipple" or "true" nipple discharge. These terms are used in describing nipple discharge because they assist the clinician by separating the pathology and treatment of both.

Pseudonipple Discharge

Pseudonipple discharge is fluid discharge from the breast that is not produced within the mammary glands, lobules, lactiferous sinuses, or lactif-

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Clinical Challenge of Nipple Discharge

erous ducts. The majority of the patients with this type of discharge will experience excoriation and drainage around the nipple papillae. Commonly, pseudonipple discharge is related to hygiene or trauma to the nipple/areolar complex.

Causes

Common causes of pseudonipple discharge include superficial infections from *Staphylococcus aureus*, *Streptococcus species*, *Bacteroides*, and herpes simplex virus. A periareolar abscess and mammary fistula (i.e., mammary duct or a lactiferous duct fistula) may be mistaken for true nipple discharge because purulent material will drain directly from the nipple. In fact, an inverted nipple is the most common cause of a mammary duct fistula. If a woman has inverted nipples, the normal skin flora, combined with secretions from the Montgomery glands, produces a bacterial culture medium that collects in the fold between the areola and the inverted nipple. This creates a superficial abscess that can rupture into a lactiferous sinus, causing a fistula between the skin and a lactiferous duct.⁷

Traumatic lesions (ie, jogger's nipples) are becoming more common as women participate in more sports and exercise programs. Eczematoid lesions can cause a discharge that can be mistaken for true nipple discharge. Care should also be taken not to mistake one of these benign breast lesions for an underlying breast cancer.

Treatment

The treatment of pseudonipple discharge begins with improved nipple hygiene techniques. The patient is instructed to cleanse her nipples and areola with cotton balls and to use an antibacterial soap such as PhisoHex®. The woman with inverted nipples is instructed to evert the nipple by pressing down on the areola and causing the nipple papilla to protrude. She can then adequately clean the nipple and areola. The treatment for "jogger's nipples" is to instruct the patient to wear a well-fitting, supportive brassiere during periods of exercise. If this treatment is unsuccessful, she may need to alter her exercise program. Eczematoid lesions of the nipple and areola can be treated with a good hygiene program, along with topical creams and corticosteroids.

Mammary duct fistulas and eczematoid lesions of the nipple require surgical intervention if medical treatment fails. A mammary duct fistula is treated by a fistulotomy to externalize the ab-

cess and establish adequate drainage. The abscess cavity remains open to heal by secondary intention. When the nipple is everted by surgery, this corrects the underlying anatomical defect and prevents new or reoccurring mammary duct fistulas.⁸ A nonhealing eczematoid lesion of the nipple must be biopsied to exclude Paget's disease of the nipple.⁹

True Nipple Discharge

True nipple discharge is fluid discharge that is produced from the mammary glands, lactiferous ducts, or lactiferous sinuses. Most patients with this type of discharge experience either medical or surgical galactorrhea.

Lactation is the anticipated true nipple discharge in postpartum women who are nursing infants. If the patient is not postpartum and has experienced true nipple discharge within 6 months after breast feeding is discontinued, the discharge is referred to as galactorrhea.¹⁰

Galactorrhea

Medical. Medical galactorrhea is a milky, multicolored, or sticky discharge produced from both breasts that will often respond to medical treatment. It can be the result of normal secretions during a woman's reproductive years. The largest population of patients in this category present with idiopathic galactorrhea and normal menses. The majority of these women have postpartum lactation and normal prolactin levels.¹¹ With each menstrual cycle, the breast tissue reacts to the cyclical variations of estrogen and progesterone. As a result, the epithelium lining the lactiferous ducts exfoliates into the duct, and nipple discharge may occur. This type of discharge usually appears at the same time during the menstrual cycle and is multicolored, bilateral, and will appear at multiple locations on the nipple papilla, indicating that multiple ducts are affected. Frequently, this same discharge can be expressed while the woman is conducting her monthly breast examination.

Medications cause galactorrhea by altering the endocrine pathway for lactation. Conditions that affect the follicle and corpus luteum of the ovary include syndromes such as Stein-Leventhal, Chiari-Frommel, Forbes-Albright, and Ahumada-del Castillo; all result in direct stimulation of the mammary glandular tissue and breast lobules.¹² Exogenous estrogen and oral contraceptives also cause galactorrhea by this mechanism. Com-

monly, the patient will be anovulatory.

The hypothalamic-pituitary axis is the second location where the endocrine pathway can be altered (Fig 1). Numerous medications will alter the hypothalamic-pituitary axis; a common mechanism is to suppress the inhibitory effect of dopamine and thus increase the secretion of prolactin from the anterior pituitary. These medications commonly are tricyclic antidepressants, antipsychotic agents, H₂ antagonists, and antihypertensive agents. Table 1 lists common medications associated with galactorrhea.

A pituitary adenoma is a cause of true nipple discharge and has an incidence rate of 2.2%¹ to 47.5%¹³. Additional symptoms of prolactinoma include headaches, a bilateral nipple discharge, infertility, and a bilateral temporal visual field defect. Patients with multiple endocrine neoplasia-1 (MEN-1) syndrome will often have a prolactinoma as the pituitary adenoma. These patients also will have elevated prolactin levels, and the pathology of the pituitary tumor is classified as a chromophobe adenoma. In the majority of patients with galactorrhea associated with an endocrine disorder (ie, medications and syndromes that alter the corpus luteum and the hypothalamic-pituitary axis), the result is bilateral discharge that is produced from multiple ducts and resembles breast milk. Figure 1 summarizes the hypothalamus-pituitary axis and the common sites where the endocrine pathway for lactation is altered.

Mammary duct ectasia can be thought of as the end result of the lactiferous ducts and sinuses responding to the constant variation in estrogen and progesterone levels. It is a common cause of multicolored sticky nipple discharge. The discharge can originate from a single duct or multiple ducts and is often bilateral. An excisional biopsy will show fibrosis and scarring of the lactiferous ducts and sinuses filled with acellular material and desquamated epithelium.¹²

Surgical. A complete history and physical examination is invaluable to determine the pathophysiology, assess the risk of malignancy, and plan treatment when evaluating a patient with nipple discharge. The etiology of surgical galactorrhea is a pathological abnormality of the lactiferous ducts. Intraductal papilloma, fibrocystic change, breast abscess, and a malignant neoplasm are causes of surgical galactorrhea. Key elements in the patient history include the character of the discharge and the location of the discharge from the nipple. Commonly, galactorrhea

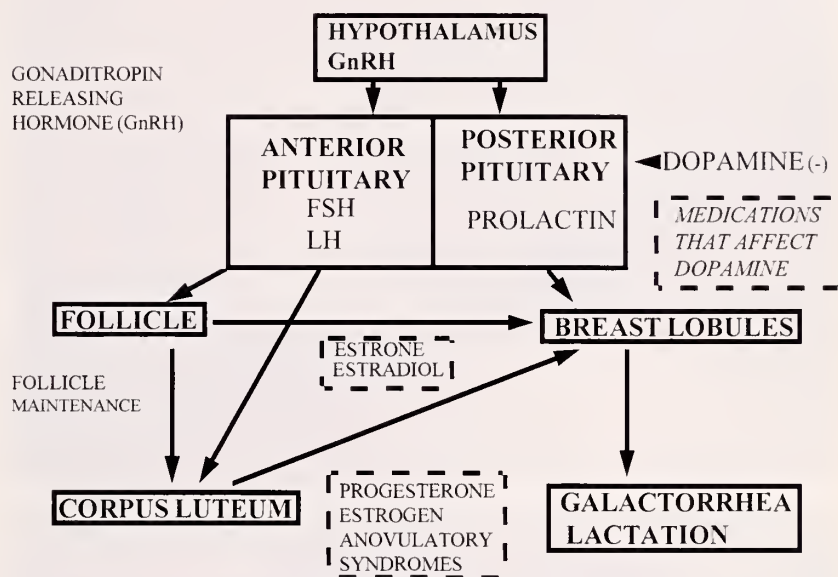


Fig 1 — The hypothalamic-pituitary axis in relation to lactation and galactorrhea. The boxes with solid lines represent the location where the specific hormone is stored and released in the endocrine pathway. The boxes with dashed lines represent medications and syndromes that affect the endocrine signal at the specific location. The solid arrows show the direction in which the endocrine pathway progresses. Note that there is no specific hormone that triggers negative feedback; however, dopamine constantly suppresses the release of prolactin from the anterior pituitary. (–) suppress; Gn-RH, gonadotropin releasing hormone; FSH, follicle stimulating hormone releasing hormone; LH, luteinizing hormone.

Table 1. Medications Associated with Galactorrhea

| |
|---------------------------------------------------------|
| Dopaminergic Medications |
| Tricyclic antidepressants |
| Psychotropic drugs |
| Benzodiazepines |
| Cimetidine |
| Ranitidine |
| Monoamine oxidase inhibitors |
| Metoclopramide |
| Amphetamines |
| Haloperidol |
| Methyldopa |
| Reserpine |
| Verapamil |
| Medications that Alter Estrogen and Progesterone |
| Oral contraceptives |
| Exogenous estrogen |
| Conjugated estrogens |

Clinical Challenge of Nipple Discharge

that requires surgical intervention is produced from a single lactiferous duct. The fluid is discharged from the nipple papilla, and the majority of the time the discharge is unilateral. Spontaneous discharge is more characteristic of surgical galactorrhea; however, a nipple discharge that is elicited by compression must also be evaluated for any pathological abnormality. Many patients will be aware of a specific location or "trigger point" on their breasts that, when compressed, will reproduce the nipple discharge.¹⁰

The character of the fluid is described as sanguineous or bloody, serosanguineous or pink, serous or yellow, and watery or clear.¹⁰ For example, fluid from an intraductal papilloma is often bloody, while discharge from a malignant neoplasm can also be bloody or watery and clear. For fibrocystic disease, the nipple discharge usually is serous and clear.

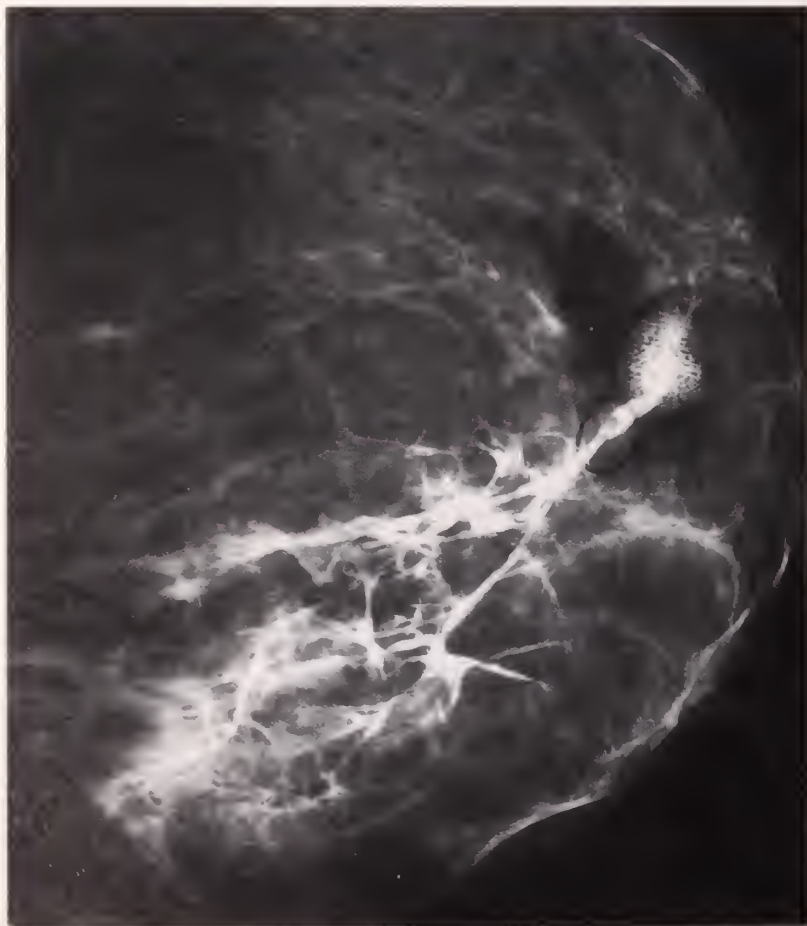


Fig 2 — A galactogram shows a filling defect in a single lactiferous sinus. The radiopaque dye fills the remainder of the collecting system.

A breast abscess often requires surgical incision and drainage. This is different from a mammary duct fistula because the breast abscess is located within the parenchyma of the breast. In a lactating patient, an abscess or mastitis can be caused when a suckling infant introduces bacteria from his or her mouth, and from the normal flora of the nipple and areola, into the lactiferous ducts and sinuses of the breast. Treatment involves the application of local heat to the breast, a gentle massage over the abscess, and oral antibiotics. Appropriate antibiotics should provide adequate coverage for *Staphylococcus aureus*, *Streptococcus species*, *Bacteroides*, and anaerobic *Streptococcus*. The infant may need to be weaned for the mastitis to resolve. If medical management fails, then surgery is required to drain the abscess.

The nonlactating woman with a breast abscess will often have the same etiology for a breast abscess as the lactating woman, in that bacteria from the nipple and areola can be introduced into the lactiferous ducts and sinuses. However, in a nonlactating woman, a necrotic breast cancer can be misdiagnosed as a breast abscess. A breast abscess in a nonlactating woman should be surgically drained and a biopsy of the abscess wall examined by a pathologist.

The diagnostic evaluation of the patient with a suspected surgical galactorrhea involves a systematic approach. If a palpable mass is present on examination, mammography is conducted, followed by an excision biopsy of the mass and other suspicious lesions. The patient without a palpable breast mass, but with nipple discharge, can be diagnostically more challenging. A complete history should include the color, frequency, and location of the discharge. Is the discharge produced from the nipple papilla or from the areola? The clinician should correlate the occurrence of the discharge with the patient's menstrual cycle, and a list of all medications that the patient is taking should be obtained. The clinician should determine if the discharge is spontaneous or elicited by breast manipulation. If there is a "trigger point" in which the patient can compress the breast and cause the discharge, the clinician should also be able to elicit a discharge during examination. If this is unsuccessful, however, the patient is instructed to paint her nipple with topical collodion daily for one week and return to the clinician's office.¹⁴ The collodion will cause the discharge to build up in the ductal system. The collodion can then be removed for the examiner to identify the specific duct where the dis-

charge is produced and to perform cytology and plan surgical therapy. A mammogram is obtained to identify coexistent abnormalities such as microcalcifications that may be associated with the nipple discharge.

If no mass is palpated or no abnormality can be identified on the mammogram, a galactogram should be ordered to determine the pathology within the ductal system of the breast.¹⁵ A galactogram is performed by cannulating the orifice of the duct where the discharge was elicited. Radiopaque contrast dye is injected, and a mammogram is repeated to define the geography of the ductal system. Figure 2 shows a filling defect within the lactiferous sinus. The galactogram (Figure 2) was ordered to determine the cause of bloody nipple discharge from a single duct of a 53-year-old postmenopausal woman.

Once the pathological abnormality is determined, the surgeon and the patient have two treatment options: a central or single lactiferous duct excision. A complete central lactiferous duct excision of the affected breast can be performed to remove all of the lactiferous ducts and sinuses of the breast. The advantage is that it will prevent further nipple discharge from the breast, eliminate the possibility of missing multiple intraductal papillomas, and decrease the incidence of not removing all of the diseased lactiferous duct, lactiferous sinus, and mammary gland tissue. Disadvantages include the possibility of cosmetic deformity around the nipple/areolar complex, and if the woman is of childbearing age, this procedure could limit her ability to breast-feed.

The other alternative is to surgically remove only the diseased lactiferous duct, sinus, and mammary gland tissue. This is a single duct excision, which has the advantage of preserving breast tissue in women of child-bearing age who want to breast-feed. The disadvantage is the possible failure to excise the involved lactiferous duct, thereby resulting in a false-negative biopsy. Figure 3A shows a blunt-tipped cannula after it has been inserted into the orifice of the abnormal lactiferous duct. A syringe containing methylene blue dye is attached to the catheter for supplemental injection into the ductal system. The surgeon can then visualize the abnormal duct during the operation (Fig 3B).

Conclusions

The breast responds to the hormonal milieu of puberty, menstruation, pregnancy, lactation, and

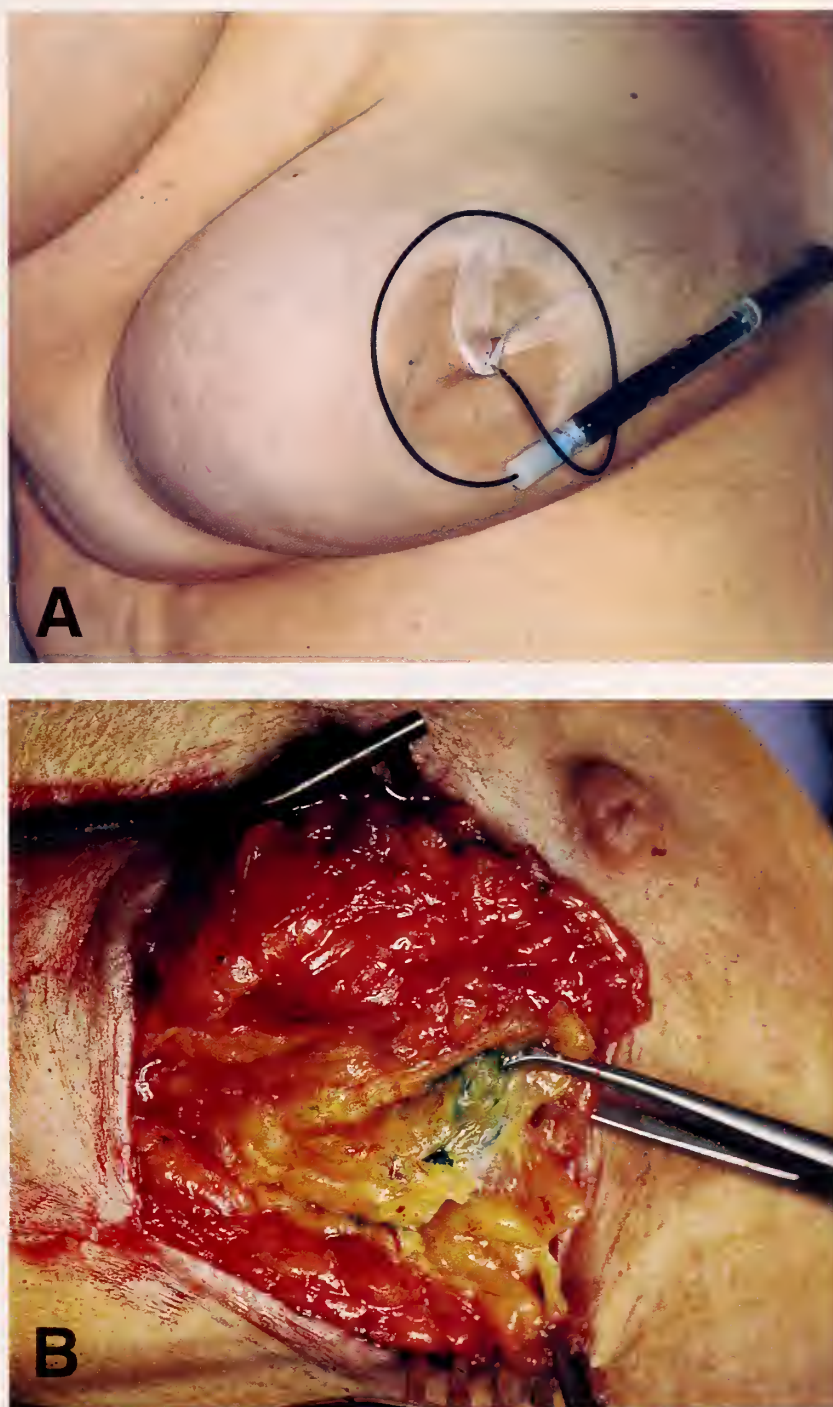


Fig 3 — (A) The lactiferous duct catheter is placed into the orifice of the abnormal lactiferous duct. (B) The tissue clamp is used to grasp the affected duct (depicted in blue) and associated mammary gland tissue.

menopause. A detailed history and physical examination with an emphasis on the location, character, duration of the discharge, frequency of occurrence, and a detailed history of medications and past surgeries are essential in differentiating the numerous causes of nipple discharge. The clinician should always consider the risk of malig-

Clinical Challenge of Nipple Discharge

Table 2. Risk Factors For Cancer that are Associated with Nipple Discharge

| Lesser Risk for Malignancy | Greater Risk for Malignancy |
|----------------------------|-----------------------------|
| Age < 50 years | Age > 50 years |
| Elicited | Spontaneous |
| Multiple ducts | Single ducts |
| Bilateral | Unilateral |
| Female | Male |

nancy associated with both pseudonipple discharge and true nipple discharge. Table 2 provides a summary of risk factors for malignancy as it relates to nipple discharge. A combination of diagnostic tests, including laboratory evaluation, mammograms, and galactograms can help the clinician establish the diagnosis and plan proper treatment.

ACKNOWLEDGMENT: The author would like to thank the Department of Surgery Editorial Office for assisting in the preparation of this manuscript.

References

1. Newman HF, Klein M, Northrup JD, Ray BF, Drucker M. Nipple Discharge. Frequency and pathogenesis in an ambulatory population. *NY State J Med* 1983;83:928-933.

2. Leis HP Jr, Cammarata, A. Nipple discharge: evaluation, cancer association and management. *Am J Diagnostic Gynecol Obstet*. 1979;1:43-47.
3. Devitt JE. Management of nipple discharge by clinical findings. *Am J Surg*. 1985;149:789-792.
4. Haagensted CD. *Diseases of the breast*; 3rd ed. Philadelphia: WB Saunders, 1986:8-14.
5. Kuhns JG, Ackermann DM. Microscopic anatomy of the breast. In: Donegan WL, Spratt JS, eds. *Cancer of the breast*; 4th ed. Philadelphia: WB Saunders, 1995:16-21.
6. Bland KI, Copeland EM, eds. *The breast comprehensive management of benign and malignant diseases*. Philadelphia: WB Saunders, 1991:40-41.
7. Zuska JJ, Crile G, Ayres WW. Fistulas of lactiferous ducts. *Am J Surg*. 1951;8:312-317.
8. Khoda J, Lantsberg L, Yegev Y, Sebbag G. Management of periareolar abscess and mammillary fistula. *Surg Gynecol Obstet*. 1992;175:306-308.
9. Paget JB. On the disease of the mammary areola preceding cancer of the mammary gland. *St. Barth Hosp Rep*. 1874; 10:87-89.
10. Leis HP. Management of nipple discharge [Review]. *World J Surg*. 1989;13:736-742.
11. Frantz AG, Wilson JD. Endocrine disorders of the breasts. In: Wilson JD, Foster DW, eds. *William's textbook of endocrinology*; 7th ed. Philadelphia: WB Saunders, 1985:402-421.
12. Fiorica JV. Contemporary management of breast disease 1: benign disease. *Obstet Gynecol Clin North Am*. 1994;21:453-460.
13. Katz E, Adashi EY. Hyperprolactinemic disorders. *Clin Obstet Gynecol*. 1990;33:622-639.
14. Donegan WL, Spratt JS, eds. *Cancer of the breast*; 4th ed. Philadelphia: WB Saunders, 1995.
15. Cardenosa G, Doudna C, Eklund GW. Ductography of the breast: technique and finding. *AJR Am J Roentgenol*. 1994; 162:1081-1087.

Hot Tub Legionellosis

Arthur Tolentino, MD; Sunket Ahkee, MD; Julio Ramirez, MD

Legionella pneumophila is the cause of Legionnaires' disease, and Pontiac fever, an influenza-like condition without pneumonia. We present a case of Pontiac fever after exposure to a hot tub contaminated with *L. pneumophila*. A 37 y/o w/f presented to the office with acute onset of sore throat, fever, headache, and myalgia. Patient was hospitalized 3 days later because of worsening shortness of air. Chest x-ray was normal. Patient was treated with 2 days of IV erythromycin and was discharged home on oral erythromycin. Her *Legionella* IFA was 1:16,384. Two days later, she developed chest tightness, pleuritic chest pain, and increasing shortness of air but did not have any cough or sputum production. She was re-hospitalized with a diagnosis of Pontiac fever and treated with IV erythromycin plus oral rifampin. A repeat chest x-ray remained normal. After a detailed epidemiologic history was obtained, it was noted that she became ill after using a hot tub, which her two children also used and they themselves developed a self limited illness. Water from the hot tub was positive for *L. pneumophila* by DFA, culture, and PCR. Patient improved gradually with therapy and was discharged home. This report emphasizes the importance of a complete epidemiologic history in the diagnosis of respiratory infections. It also demonstrates that aquatic environment can be contaminated with *Legionella* and serve as a source of infection.

L*egionella pneumophila* is the cause of Legionnaires' disease, a severe pneumonia, and Pontiac fever, an influenza like condition without pneumonia. *Legionella* species are found in aquatic environment and are spread by aerosolization. Outbreaks of the illness are usually associated with water sources.^{1,2}

We report a case of Pontiac fever after exposure to water from a hot tub, contaminated with *L. pneumophila*.

Case report

A 37-year-old white female presented with an acute onset of sore throat, fever, headache, malaise, and myalgia. While on treatment with amoxi-

cillin, patient developed shortness of air with pleuritic chest pain. Her antibiotic was changed to clarithromycin.

Patient was hospitalized 3 days later because of worsening shortness of air. Admission chest x-ray was normal. White blood cell count was 7,100/mm³ with 71% granulocytes, 23% lymphocytes and 6% monocytes. The blood chemistries were normal except for a low phosphorus of 2.4 mg/dl. Patient treated with intravenous erythromycin for 2 days and discharged home on oral erythromycin. Her *Legionella* indirect fluorescent antibody (IFA) titer was 1:16,384.

Two days after discharge, patient developed chest tightness, pleuritic chest pain, and increasing shortness of air but did not have any cough or sputum production. Patient was again hospitalized and this time treated with intravenous erythromycin plus oral rifampin. A repeat chest x-ray remained normal. Complete blood count and blood chemistries were repeated and were normal.

After a detailed epidemiological history was obtained, it was noted that she became ill after using a hot tub. Her two children who also used the hot tub developed self limiting illness characterized by fever and sore throat.

Water from the hot tub was positive for *L. pneumophila* by direct fluorescent antibody (DFA), polymerase chain reaction (PCR), and culture. The patient gradually improved with antibiotic therapy and was discharged home.

Discussion

Pontiac fever is named after the city of Pontiac, Michigan, where it was first detected in an outbreak at a public health building in 1968.^{1,2} It is an acute febrile illness characterized by fever, chills, malaise, myalgia, and headaches. Pontiac fever has a short incubation time of 1 to 2 days, is usually self limited, and does not progress to pneumonia.

Because both Legionnaires' disease and Pontiac fever have occurred in common source outbreaks involving the same organism, there appears to be an element of opportunism involved

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Hot Tub Legionellosis

in the process.³ Differences in immune response of the hosts and the inoculum size may determine which individuals may develop either of the diseases.⁴ Cell mediated immunity appears necessary for the host to overcome the infection.⁵ Several outbreaks of Pontiac fever have been associated with hot tub with evidence of *L pneumophila* contaminating the water.^{6,7,8}

Laboratory detection of *L pneumophila* can be done by culture, DFA, and PCR. IFA can be performed on serum samples for acute and convalescent titer. A radioimmunoassay procedure can detect Legionella serogroup 1 antigens in the urine.^{1,4,5}

Our patient had an acute onset of illness with flu-like symptoms but without pneumonia after using a hot tub. All of these are consistent with the clinical presentation of Pontiac fever. The diagnosis was obtained by IFA. The water from the hot tub which was positive for *L pneumophila* was most likely the source of infection.

Coincidentally, with the use of rifampin plus erythromycin the patient's clinical status improved. The self limited illness of the patient's two children was probably secondary to exposure to smaller inoculum size.

Conclusion

This report emphasizes the importance of a complete epidemiologic history in the diagnosis of respiratory infections. It also demonstrates that aquatic environment can be contaminated with *L pneumophila* and can serve as a source of infection.

References

1. Mandell GL, Douglas RG, Bennett JE. *Principles and practice of infectious diseases*. 3rd ed. Churchill Livingstone Inc; 1990.
2. Kaufmann A, McDade J, Patton C, et al. Pontiac fever, isolation of the etiologic agent (*Legionella pneumophila*), and demonstration of its mode of transmission. *Am J Epidemiol*. 1981;114:337-347.
3. Kurtz JB. *Legionella pneumophila*. *Ann Occup Hyg*. 1988;32:59-61.
4. Barron EJ, Finegold S. *Bailey and Scott's diagnostic microbiology*. St. Louis, MO. CV Mosby; 1990.
5. Gorbach SL, Bartlett JG, Blacklow NR. *Infectious diseases*. WB Saunders; 1992.
6. Miller LA, Beebe JL, Butler JC, et al. Use of polymerase chain reaction in an epidemiologic investigation of Pontiac fever. *J Infect Dis*. 1993;168:769-772.
7. Mangione EJ, Remis RS, Tait KA, et al. An outbreak of Pontiac fever related to whirlpool use, Michigan 1982. *JAMA*. 1985;253:535-539.
8. Spitalny KC, Vogt RL, Orciari LA, Witherell LE, Etkin P, Novick LF. Pontiac fever associated with a whirlpool spa. *Am J Epidemiol*. 1984;120:809-17.

Occupational Fatalities in Kentucky — 1994

Tim W. Struttman, MSPH; Ellyn Moon-Hampton, MA; Amy Scheerer, BS;
Susan H. Pollack, MD; Carl Spurlock, PhD

In Kentucky, seven out of nine industry groups exceed the national average fatality rates; in 1994, the agriculture/forestry/fishing industry rate of 80/100,000 was more than three times the national average. This paper describes the occupational fatality data collected during the first year of operation (1994) of the Fatality Assessment and Control Evaluation (FACE) Project in Kentucky. Investigators used multiple reporting sources to identify incidents, which were then systematically recorded and updated. On-site investigations were conducted for certain categories of fatalities. One hundred sixty-six occupational fatalities were recorded for 1994. Motor vehicle incidents were the most common cause of death, followed by machine-related incidents. Ages of victims ranged from 15 to 86 with a median of 46. Investigators completed 22 on-site visits during the period. In this article, descriptive statistics are presented, as well as suggestions for ways the medical community might contribute to the occupational fatality prevention effort.

Background

Nationally, one-sixth of all injury deaths occur on the job.¹ On average, 17 workers die each day in the United States. Between 1980 and 1989 the average annual occupational fatality rate for the US civilian labor force was 7/100,000²; Kentucky's rate is 9/100,000 (FACE data 1994). In Kentucky, 166 workers were killed on the job in 1994. Our occupational fatality rate exceeds all contiguous states except West Virginia.³

One of the Centers for Disease Control's national objectives is to reduce the annual occupational death rate to no more than 4/100,000 by the year 2000.⁴ Clearly it will take a concerted effort from physicians, public health officials, labor force representatives, researchers, and educators to achieve this goal in Kentucky.

To prevent and control occupational injury deaths we must precisely describe who is fatally injured at work, in what industry, and by what cause. A partnership of the Kentucky Department for Public Health and the University of Kentucky Chandler Medical Center has created the Kentucky Injury Prevention and Research Center. One element of the Injury Center's Occupational Injury Prevention Program is the Fatality Assessment and Control Evaluation (FACE) Project, which uses surveillance data and comprehensive case investigations in order to develop injury prevention strategies. Kentucky is one of 14 states participating in this project, which is funded by the National Institute for Occupational Safety and Health (NIOSH).

The objectives of the FACE Project are to:

- conduct surveillance of all occupational deaths;
- identify work situations at high risk for fatal injury;
- evaluate causal factors for targeted categories of fatal injuries; and,
- formulate and disseminate prevention strategies to those who can intervene in the workplace.

The on-site investigations and prevention strategy development of the FACE Project go beyond other surveillance programs in working toward reduction of occupational fatalities in Kentucky. This paper describes the data collected during the first year of the project's operation.

Methods

An occupational fatality was defined as a death that occurs while an individual is working. Standardized criteria established by the Association for Vital Records and Health Statistics (AVRHS)^{2,3,5} were used to define the concept of work:

From the Kentucky Injury Prevention and Research Center, Chandler Medical Center, University of Kentucky. (Dr Pollack is in the Departments of Pediatrics and Preventive Medicine at the University of Kentucky College of Medicine.)

Source of Support: National Institute for Occupational Safety and Health (Cooperative Agreement #U60/CCU409879-03).

Occupational Fatalities in Kentucky

Operational Guidelines for Determination of Injury at WorkCriteria when on employer premises:

- Engaged in work activity, apprentice, vocational training
- On break; in hallways, restroom, cafeteria, storage area
- In employer parking lot while working, arriving or leaving

Criteria when not on employer premises:

- Working for pay or compensation, including at home
- Working as a volunteer EMS, firefighter or law enforcement officer
- Working in family business, including family farm (Activity should be clearly related to a profit-oriented business.)
- Traveling on business, including to and from customer/business contacts (excludes commuting)
- Engaged in work activity where vehicle is considered the work environment

Heart attack deaths which occur on the job are not included unless the medical examiner's report or autopsy indicates that the heart attack was due to overexertion or trauma. Cases in which death occurred in another state were included if the injury occurred in Kentucky.

Investigators used multiple reporting sources to identify occupational fatalities in Kentucky during a 1-year period beginning January 1, 1994. Sources included county coroners, the Occupational Health Nurses in Agricultural Communities (OHNAC) Project,[†] emergency medical personnel, Kentucky Labor Cabinet's Census of Fatal Occupational Injuries (CFOI),[‡] Kentucky State Police's Fatal Accident Reporting System (FARS),^{‡‡} Kentucky Vital Statistics Registrar, newspapers, and radio and television news reporters.

Trained data coordinators maintained electronic and paper copies of accumulated data. Data were entered into EPI INFO, a word processing, data base and statistics program designed specifically for epidemiological purposes.⁶ Data entered included demographics and all necessary information to describe the incident, but excluded any personal identifiers such as name of decedent or employer. Information describing the occupation⁷ and industry⁸ of the decedent, as well as the type of injury,⁹ was coded for entry into the data base.

An industrial hygienist conducted on-site investigations for selected categories of fatalities. (In 1994 these categories, which are determined by NIOSH, were electrocutions, falls, machine-related, and confined-space deaths.) Twenty-two case investigations were completed during the period of this study. In these instances the investigator traveled to the scene to photograph and measure the area (eg, slope, distance, opening height). Interviews with the county coroner and any witnesses, employers, family members, law enforcement personnel, or others involved with the case were conducted. The investigator developed prevention strategies after reviewing the circumstances prior to, during, and after the event. Copies of a narrative which included these prevention recommendations were mailed to all parties involved in the investigation. Twice during the year copies of all such reports were also mailed to health and safety professionals, physicians, researchers, agricultural extension agents, and others who were in a position to effect workplace change.

Results

In 1994, KY FACE identified 166 occupational fatalities, an average of more than three per week. Ninety-two percent of these deaths were males ($n = 153$), although men make up only 58% of the part- and full-time work force.¹⁰ Of the 13 females (8%) killed on the job, eight (62%) worked in a service industry, two in agriculture, and one each in construction, retail trade, and manufacturing. The median age of females (29) was significantly lower than that of males (47). The leading cause of female fatalities was homicide (8). Females made up 54% of the work-related homicide fatalities in Kentucky.

The decedents were primarily white (93.3%) and ranged in age from 15 to 86. Age groups accounting for the most fatalities were 30-39 years (25.3%) and 50-59 years (22.8%) (See Fig 1); nearly half of all deaths of those over age 50 were among farmers. Monthly distribution of the fatalities is shown in Fig 2; over one-third occurred in July, August, and September. On a per-day basis, April had the lowest rate.

KY FACE identified over half (56.6%) of the occupational fatalities within 1 week of death and 45.8% within 2 days, providing the opportunity to obtain additional information in a timely manner. Nearly all of the workers (89.8%) died within 1 day of the incident; another 4.8% died within 1

week. CFOI ($n = 40$) and newspapers ($n = 33$) were two primary sources of initial notification of incidents.

The industry for each worker at the time of death was classified using the Standard Industrial Classification (SIC) Manual 1987.⁸ The number of fatalities per industry and industry-specific death rates are shown in Table 1. As shown in Fig 3, the highest number of fatalities occurred in the agriculture/forestry/fishing industry ($n = 47$). Further industry division reveals that 45 of those deaths occurred in agricultural incidents, accounting for 27.1% of the total number of fatalities in Kentucky. Of the 22 deaths in the manufacturing industry, over half (54.5%) occurred in logging operations.

With respect to occupations, farming/forestry/fishing, which includes both agricultural and logging occupations (see Fig 4), accounted for more than one-third (34.9%) of all work-related deaths in 1994. Twenty-four workers were killed while doing work that was not their usual occupation. Of those, 17 were fatally injured while engaged in farming activities.

External causes of death are shown in Fig 5. Motor vehicle incidents were the most frequent cause (28.3%), followed by machine-related incidents (24.1%). It is important to note that the motor vehicle category includes farmers killed while traveling during the course of their work, but that, for this analysis, all incidents involving tractors were classified as machine-related. Of the 40 machine-related incidents, 29 (72.5%) involved agricultural machinery, with the most common type being tractors. Of the 28 tractor-related deaths, 23 were caused by tractor rollovers.

Investigators analyzed information from 153 completed death certificates. When available, education, marital status, whether an autopsy was performed, and the "injury at work" response were recorded. Of the 109 which included education information, education ranged from 3 to 17 years; 70 (64%) of the 109 had a high school education or more. Of the 152 with marital status recorded, 70% of the decedents were married, 14% never married, 12% divorced, and the remaining widowed. Of the 152 with autopsy information, 48% indicated that an autopsy had been performed. Fifteen percent ($n = 23$) of the 153 erroneously indicated that death was not the result of an injury at work; six were left blank.

Twenty-two on-site investigations were conducted in 21 Kentucky counties during 1994.

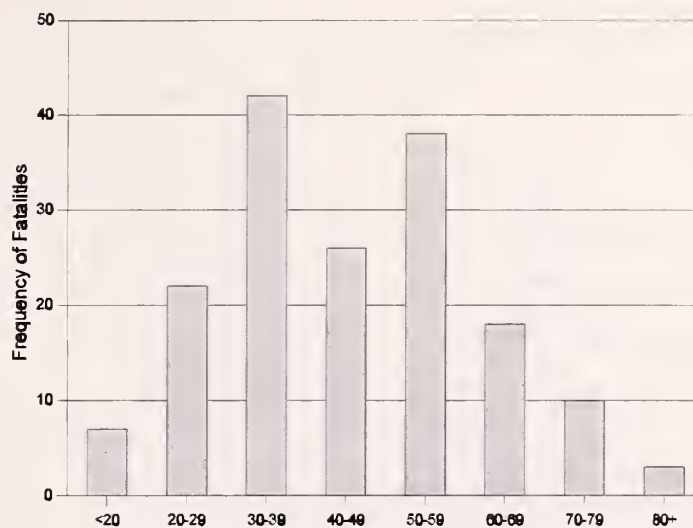


Fig 1 - Fatalities by Age Group.

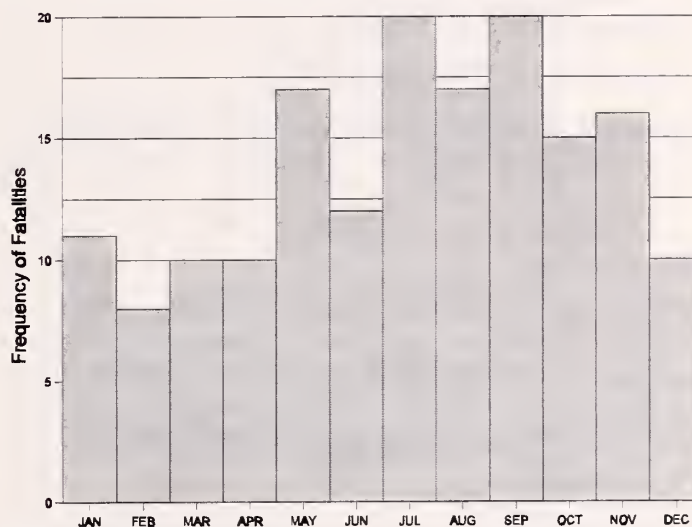


Fig 2 - Fatalities per Month.

Table 1. Occupational Fatalities in Kentucky by Industry, 1994. (Rates calculated per 100,000 workers^a)

| Industry ^b | (n) | KY Rate | US Rate ^c |
|---------------------------------|--------------|---------|----------------------|
| Agriculture/Forestry/Fishing | 47 (28.3%) | 80 | 26 |
| Construction | 25 (15.0%) | 26 | 14 |
| Manufacturing | 22 (13.3%) | 7 | 4 |
| Transportation/Public Utilities | 22 (13.3%) | 22 | 13 |
| Services | 16 (9.6%) | 5 | 2 |
| Retail/Wholesale Trade | 12 (7.2%) | 4 | 5 |
| Mining | 11 (6.6%) | 32 | 26 |
| Public Administration | 8 (4.8%) | 3 | 3 |
| Finance/Insurance/Real Estate | 3 (1.8%) | 4 | 2 |
| Totals | 166 (100.0%) | 9 | 5 |

^a Labor force census obtained from Geographic Profile of Employment and Unemployment, 1993 US Department of Labor Statistics, September 1994, Bulletin 2446.

^b Office of Management and Budget. Standard Industrial Classification Manual. 1987. Springfield, VA: National Technical Information Service. (NTIS Na. PB 87-100012.)

^c Monthly Labor Review, October 1994, Fatal Occupational Injuries by Industry and Event or Exposure, 1993. Census of Fatal Occupational Injuries, 1993.

Occupational Fatalities in Kentucky

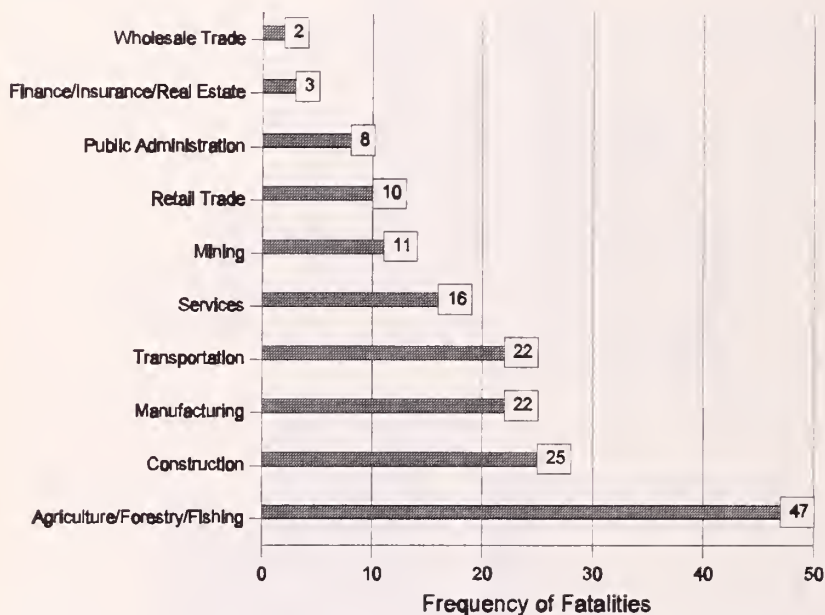


Fig 3 — Fatalities by Industry.

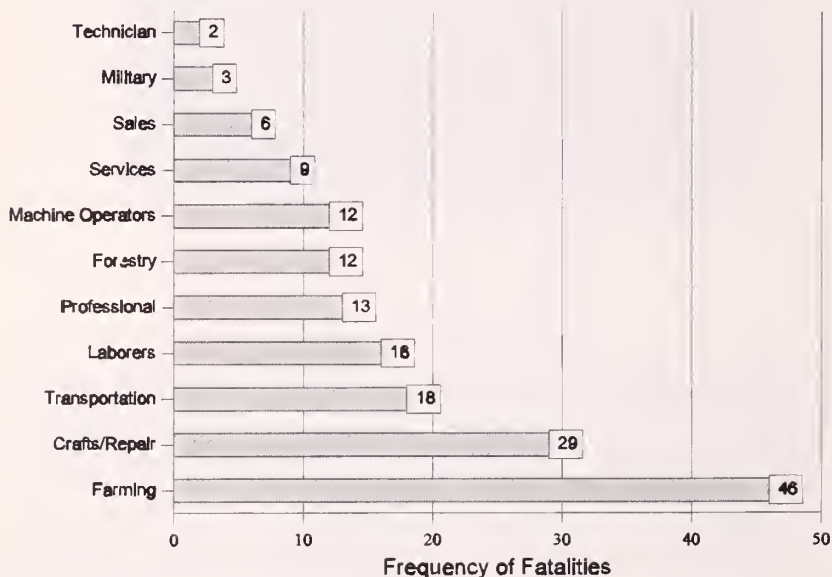


Fig 4 — Fatalities by Occupation.

These included 20 machine-related incidents (18 farm, 1 logging, 1 other) and two falls. Twenty-four different recommendations were made for prevention of similar incidents. These recommendations included mechanical modifications of equipment, safety training, and installation of operator protective devices, as well as suggestions

for improved emergency response systems. More than 470 copies of these reports were disseminated during the year.

Discussion

When compared to US rates, Kentucky has a higher death rate in seven of nine industry classifications as well as a higher total rate for all workers. (See Table 1.) Most striking is the rate found in the industry of agriculture/forestry/fishing where there were 80 deaths per 100,000 workers, which is three times higher than the US rate of 26 per 100,000 workers. FACE data suggest three likely reasons for this. First, bi-vocational farmers (those who work other jobs in addition to farming) accounted for one-third of the agricultural deaths. Individuals who identify an industry other than agriculture as their primary one might not be included in an agricultural census count. As well, such individuals may be at higher risk due to longer working hours, lack of experience and/or training, and the increased stress that results from time constraints. Second, the median age of the 42 agricultural workers was 60.5, whereas the median age in all other industries was 39, suggesting an older workforce and consequent increased risk.¹¹ Third, investigators found a number of older model tractors with minimally operable brakes. Average tractor age involved in the incidents was 25 years, whereas for the US the average tractor age was 22.8 years.¹² In 23 tractor rollover cases, the fatalities might have been prevented if the tractors had been fitted with rollover protective structures (ROPS) and seatbelts.¹³

Alternatively, it is possible that some portion of Kentucky's high agricultural fatality rate could be accounted for by differences in case identification and reporting. For example, FACE investigators confirmed an occupational relationship in 23 cases where the death certificates had negative responses to the "injury at work" question. Seventy percent ($n = 16$) of these were in the agricultural industry. This is higher than found by other researchers in farming.¹¹ Of the 70%, nine held other jobs in addition to farming, three were retired but continued to farm, and four were full-time farmers.

Kentucky's second-highest rate for 1994 was in the construction industry. This rate also exceeded the national. Causes included motor vehicles ($n = 6$), falls ($n = 6$), and electrocutions ($n = 4$). The manufacturing industry rate, nearly dou-

ble the national rate, was largely due to the inclusion of logging operations, where 12 workers were killed. The transportation, communications, and public utilities industry's death rate exceeded the national rate as well; 64% of these resulted from motor vehicle incidents.

This study has a number of limitations. First, resources were not available to complete on-site investigations of all occupational fatalities. Only 38.6% of those identified as electrocutions, falls, machine-related, and confined-space deaths were investigated; this represents only 13.3% of all 1994 occupational fatalities. Second, the difficulty of calculating an exposure period in order to determine risk factors, particularly in the agricultural setting where work hours are not clearly defined, limits more definitive conclusions. Third, long-term behaviors, attitudes, and cultural patterns were not addressed in determining causal factors.

Conclusions and Recommendations

With ongoing and systematic collection, analysis, and interpretation of statewide occupational fatality data, researchers and public health practitioners can plan, implement, and evaluate public health interventions. FACE investigations go beyond this traditional surveillance system. Using the host, energy agent, and environment model in a time sequence (pre-event, event, post-event), FACE findings not only illuminate who is being killed, by what means and where, but offer specific recommendations for preventing similar types of fatalities.

The effort to reduce Kentucky's high occupational fatality rate can and should involve the medical community. Toward this end, three recommendations are suggested. First, all physicians need to be aware of the high occupational fatality rate in Kentucky and use every opportunity to advocate safe work practices with their patients. Second, primary care physicians should take an occupational history from all patients. Third, physicians should offer prevention information such as a suggestion to install ROPS and seatbelts when an occupational history reveals tractor operation.

Areas for further research aimed at reduction of occupational fatalities should include evaluation of FACE recommendations made, in-depth analysis of the psychosocial and socioeconomic factors which might contribute to increased risk, sensitivity analysis of death certificates as a mechanism to identify work-related deaths, and factors

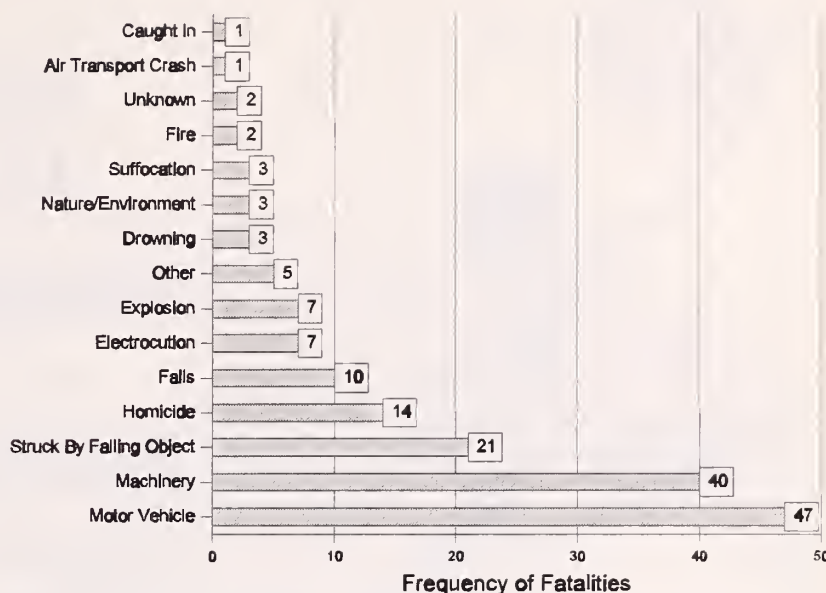


Fig 5 — Occupational Fatalities by Cause.

associated with violence against women in the workplace.

Endnotes

† The Occupational Health Nurses in Agricultural Communities (OHNAC) Project is a NIOSH-funded agricultural injury surveillance program in nine Kentucky counties. Registered nurses collect and record case reports on fatal and non-fatal injuries which occur on a farm or in an agricultural setting. The program has been active since 1992 and is administered by the Kentucky Injury Prevention and Research Center's Occupational Injury Prevention Program.

‡ The Census of Fatal Occupational Injuries (CFOI) is a national surveillance system of occupational fatalities administered by the Kentucky Labor Cabinet, Department of Workplace Standards, in cooperation with the US Department of Labor, Bureau of Labor Statistics.

‡† The Fatal Accident Reporting System (FARS) is a national reporting system of fatal injuries occurring on public roadways, administered by the Kentucky State Police.

References

1. Baker SP, O'Neill B, Ginsburg MJ, Li G. *The Injury Fact Book*, 2nd edition. NY: Oxford University Press; 1992.
2. National Institute for Occupational Safety and Health. *Fatal Injuries to Workers in the United States, 1980-89: A Decade of Surveillance (National Profile)*. Washington, DC: US Department of Health and Human Services; 1993. DHHS (NIOSH) Publication No. 93-108.
3. National Institute for Occupational Safety and Health. *Fatal Injuries to Workers in the United States, 1980-1989: A Decade of Surveillance (National and State Profiles)*. Washington, DC:

Occupational Fatalities in Kentucky

US Department of Health and Human Services; 1993. DHHS (NIOSH) Publication No. 93-108S.

4. US Department of Health and Human Services. *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*. Washington, DC: US Government Printing Office; 1990.

5. Operational guidelines for determination of injury at work. *JOEM*. 1995;37(2):125.

6. Dean AG, Dean JA, Coulombier D, et al. *Epi Info, Version 6: A Word Processing, Database, and Statistics Program For Epidemiology On Microcomputers*. Atlanta, GA: Centers for Disease Control and Prevention; 1994.

7. US Department of Commerce, Bureau of the Census. *Alphabetical Index of Industries and Occupations* (Publication No. 1990 CPH-R-3). Washington, DC: US Government Printing Office; 1992.

8. Office of Management and Budget. *Standard Industrial Classification Manual*. Springfield, VA: National Technical Information Service; 1987. (NTIS No. PB 87-100012).

9. Karaffa MC, ed. *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD-9-CM). Los Angeles, CA: Practice Management Information Corporation; 1993.

10. US Department of Labor, Bureau of Labor Statistics. *Geographic Profile of Employment and Unemployment, 1993* (Bulletin 2446). Washington, DC: US Government Printing Office; 1994.

11. Murphy DJ, Seltzer BL, Yesalis CE. Comparison of two methodologies to measure agricultural occupational fatalities. *Am J Public Health*. 1990;80(2):198-200.

12. Myers JR, Snyder KA. Roll-over protective structure use and the cost of retrofitting tractors in the United States, 1993. *J of Agricultural Safety and Health*. 1995;1(3):185-197.

13. Struttman TW, Spurlock C, Pollack SH, Moon-Hampton E. Farm-tractor-related fatalities — Kentucky, 1994. *MMWR*. 1995;44(26):481-484.

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The telephone is a wondrous and efficient means of communication. What it accomplishes for us in increasing the amount and quality of work we can do is hardly diminished by the disadvantage it has of encouraging the excessive and repetitive communication that some patients seem to need for satisfaction. These clients very likely would require the redundant attention they seek without the telephone which seems, to us, to encourage the abuse of excess verbiage but which would likely occur anyway. Who of us remaining can remember life without the telephone?

There is a current wave of sentiment favoring the charging of fees for telephone services and this change may be consolidating by the acknowledgment of codes for such fees by medical insurance payors,

whether or not they will pay such fees. Certainly our professional brethren, the lawyers, are charging and receiving payment for such fees.

One of the differences between lawyers and us is that lawyers are wordsmiths and we are mechanics. We hope the best of us serve our clients with ideas and imagination, but the physician is an artisan. If the medical ethicists declare that charging for telephone services is appropriate, I think I shall continue not to make such charges but rather include the time for my augmented intake of information and the improvement of the patient by virtue of my over-the-counter advice in the anticipated next physical encounter we have. At that time I shall be able to confirm or change such judgments with a thoughtful examination of the patient and continue striving to render relief and to do no harm.

A. Evan Overstreet, MD
Editor

What's in a Word?

by Wallace V. Mann, Jr, DMD

We have the great privilege to publish a guest editorial which I requested from a scholar of talent and boundless energy. Wally Mann is a distinguished dentist. Other accomplishments include the deanship of the School of Dentistry, University of Louisville, and University Provost and Vice President for Academic Affairs, University of Louisville. — A. Evan Overstreet, MD, Editor

Asked "What's in a word?" many would probably answer, "Not much," but the history of words can provide surprising insights. As Lewis Thomas points out in an essay from his book *Et Cetera, Et Cetera: Notes of a Word Watcher*, we have been on a self-destructive path of individualism, and we must change our behavior towards one another. One way to do that is to understand words and use them in the way they were meant to be used when humans first began communicating through language. After more than 30 years as a dental dean and university Provost, I am convinced there is one such word-history that all health care providers should know intimately — the history of *care* or *caring*, part of the practice lexicon of all doctors, and it should be taught early on to all medical students. The word *caring* descends from an Indo-European root *gar*, meaning 'voice.' From the same root come the words *garrire*, Latin to 'chatter,' and the Greek *gerus* 'voice.'

That makes eminent sense, doesn't it? When the world was mostly dark, the sound of a human voice was meant to give recognition and reassurance from one person to another. Through the ages the stem word for the human voice evolved to express comfort, concern and caring if you'll allow my non-expert etymological interpretation.

Business leaders also recognize the importance of caring. In a book titled *Love and Profit — The Art of Caring Leadership*, James Autry, former head of a major publishing company, says the old paradigm of the boss as the power figure is bad leadership. In its place, managers must care about their employees. They show their care by knowing how to listen and teach without doing too much for the workers; how to encourage individual risk taking while making sure they don't go too far; and how to reward and recognize the accomplishments of one while still *caring* about another who does not do as well.


In health care, let me give you a personal example of how one doctor, Charles Smith, used his voice to care for a patient — me, in this case. A few years ago, I spent a miserable weekend with dizziness, nausea, vomiting and, like most patients who don't want to trouble their doctors on weekends (or prefer to avoid hospital emergency rooms), I thought I'd tough it out until Monday. My wife called Charlie's office on Monday morning, since I couldn't stand without vomiting, and by then I was

pretty dehydrated. Dorie drove me to his office, and when Charlie examined me he told me that he was going to do something that would make me feel even worse. He asked me to follow his finger which he moved back and forth, up and down. He did, and I started to retch even harder. (By now, you've probably made the diagnosis: vestibulitis.) When I started to vomit, Charlie called for the emesis basin. What he did next, however, epitomized caring. He could have given me the basin and left me to my misery. Instead, he cradled my head in his arm, and spoke reassuring words telling me the nausea and dizziness would go away. He used his voice and physical contact to reassure me, and I will not forget how he took care of me that morning.

At the University of Louisville we use a proverb from the Ibo people of Nigeria to celebrate our diversity. I believe it is an eloquent statement about education and caring:

*Not to know is bad.
Not to want to know is worse.
Not to hope — unthinkable.
Not to care — unforgivable.*

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HIV/AIDS Bookcovers

It is indeed an honor to highlight the significant health promotion project initiated in Kentucky by Aroona (Mrs Uday) Dave, President-Elect of the Kentucky Medical Association Alliance, that is, the printing of the HIV/AIDS bookcovers/posters featured in this article. Over 30,000 bookcovers/posters were distributed in Kentucky schools with the purpose of reinforcing the HIV/AIDS prevention message being taught in three programs across the state: Reducing The Risk (RTR), Postponing Sexual Involvement (PSI), and AIDS peer training. Approved by the Kentucky Department of Education AIDS Education Technical Review Committee, the bookcovers were distributed by the Cabinet for Human Resources' Pamphlet Library in Frankfort.

This valuable health promotion service was endorsed and generously supported by the Kentucky Medical Association Public Education Committee, the Kentucky Cabinet for Health Services, the Kentucky Parent Teachers Association, the Kentucky Medical Association Alliance, the Hopkins County Department of Health, the Hopkins County Board of Education, and the Hopkins County Medical Alliance. Forming such a coalition of organizations to achieve a common goal portends well for the future in the comprehensive health education of Kentucky's youth.

It was in her role as Kentucky Medical Association Alliance's Vice-President for Health Promotion that Mrs Dave was responsible for the

implementation of this valuable project. This is one example of what her effervescent determination can bring to fruition. Like her, all Kentucky Medical Association Alliance members are to be applauded for their response to the ever-increasing challenges in the health field and their commitment toward service to others and their spouses' profession.

Ruth Ryan
KMAA President



Ruth Ryan



Holding the book cover, left to right, are Marla Vieillard, KMAA Immediate Past President; John Webb, Teen Initiative Coordinator, Cabinet for Health Services; and Aroona Dave, KMAA President-Elect.

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- Never sign any agreement that contains a pre-dispute arbitration provision.
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By Howard Eisenberg

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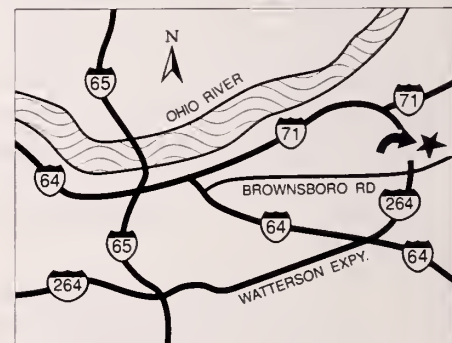
KMA Headquarters Office Moves to New Site in October

The KMA Headquarters Office will move to a new location in mid-October.

KMA's new home will encompass approximately 14,000 square feet of work area on the second floor of a newly constructed building at 4965 US Highway 42 (Brownsboro Road). The building will be called "The KMA Building."

The Brownsboro Road location is only two blocks east of I-264 in Louisville and will provide easy access from interstates and main thoroughfares for those attending meetings. The new quarters provide space for meetings of the KMA Board of Trustees and other large gatherings and will allow for future expansion as indicated.

KMA telephone and fax numbers will remain the same. Phone: 502/426-6200; Fax: 502/426-6877. The association's mailing address effective in October will be: **The KMA Building, 4965 US Hwy 42, Suite 2000, Louisville, KY 40222.**



Kentucky Medical Association
The KMA Building
4965 US Hwy 42, Suite 2000
Louisville, KY 40222

502/426-6200
Fax 502/426-6877
(These numbers remain the same)

PEOPLE

Jaroslav P. Stulc, MD, a surgeon at Trover Clinic, Madisonville, has been inducted into the International College of Surgeons. Dr Stulc serves as an Assistant Editor for *The Journal*.

Allan Tasman, MD, Chair of the University of Louisville Department of Psychiatry and Behavioral Sciences, has been elected to a 2-year term as Vice President of the American Psychiatric Association. Dr Tasman also serves as the President-Elect of the American Association of Chairmen of Departments of Psychiatry, and will assume the presidency of that organization in November of this year. He is also a past President of the American Association of Directors of Psychiatric Residency Training and of the Association for Academic Psychiatry. Dr Tasman is the only individual in the history of these three major psychiatric education organizations to serve as president of all three.

Tim Wierson, MD, FACS, of Bowling Green, recently received a 3-year appointment as Cancer Liaison Physician for the Hospital Cancer Program at HCA Greenview Hospital. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons.

George Rodgers, Jr, MD, University of Louisville Department of Pediatrics, has been elected an honorary member of the Romanian Academy of Medical Sciences.

Henry D. Garretson, MD, neurological surgery, **Mohammad Amin, MD**, surgery, and **Martin J. Raff, MD**, infectious diseases, recently celebrated 25 years of service to the University of Louisville School of Medicine.



Daniel W. Varga, MD JCMS President

Daniel W. Varga, MD, *The Journal's* Scientific Editor, was recently inaugurated President of the Jefferson County Medical Society.

Dr Varga, a Louisville internist and 1984 graduate of the University of Louisville School of Medicine, has been diligent and dedicated in his nurturance of medical education and organized medicine. He has been a faculty member of the University of Louisville Department of Medicine since the completion of his residency and has twice been awarded the Dr Stuart Graves Award for the outstanding clinical teacher. He has served for 5 years on the University of Louisville Medical School Admissions Committee, and organized and still directs the Health Promotion Schools of Excellence Program.

His involvement in organized medicine includes service as Treasurer and Board Member of the Jefferson County Medical Society (JCMS) and representation as a JCMS delegate to the Kentucky Medical Association for the past 4 years. He is KMA Alternate Trustee for the 5th District and is a member of the KMA Ad Hoc Committee to Develop a Comprehensive School Health Education Plan. A diplomate of the American Board of Internal Medicine, Dr Varga is also a member of the American Association for the Advancement of Science, American College of Physicians, and the Southern Medical Association.

Dr Varga has served as Scientific Editor of *The Journal* since 1990, and we extend our sincerest congratulations on his election to the presidency of the Jefferson County Medical Society.

UPDATES

University of Kentucky Hosts Russian Physicians

The University of Kentucky College of Allied Health Professions health administration faculty are assisting physicians at the Khabarovsk Medical University in Russia to develop an instructional health administration program. UK is one of four universities in the United States selected to form a partnership with four medical universities in Russia to develop a health administration program. Physicians from Russia recently visited faculty at the UK College of Allied Health Professions to learn more about their health administration program and how to develop a program there. **James W. Holsinger, Jr, MD, PhD**, chancellor, UK Chandler Medical Center, was among those conferring with the Russian group.

UK African-American Graduates Honored

KMA members **Yolanda Shields, MD**, and **James Harper, Jr, MD**, were among those recognized in the first University of Kentucky Chandler Medical Center special ceremony to honor graduating African-American health professions students. Sponsored by the UK Chandler Medical Center Office of Minority Affairs, the ceremony reflected a merging of traditional African and Native American rites of passage to mark the students' transition from one phase of life to the next.

The ceremony called upon graduates to remember the ancestors, elders, and teachers whose personal and collective sacrifices and support contributed to each graduate's achievement of his or her goals.

For Shorter People, Airbags May Hurt More Than Help

Shorter drivers and passengers run a greater risk of being injured by airbags, even if they wear seat belts, says **William S. Smock, MD**, of the University of Louisville emergency medicine department.

An airbag deployment is basically a small explosion that propels the airbag out at speeds up to 210 miles per hour. Injury can be caused by the airbag cover — vinyl on the driver's side, a metal plate on the passenger side — and by the force of the deploying airbag. Any "anatomical structure" — a chest, a thumb or a head — near the bag's cover when it deploys could suffer serious injury. That includes drivers under 5 feet 3 inches who sit within 6 inches of the steering wheel.

Smock says airbags still are a good idea and that their benefits outweigh potential problems.

State Legislative Regulatory Matters

Provider Tax Reduction

Effective August 1, 1996, the physician component of the provider tax was reduced from 2% to 1.5%. The reduction, which was included in House Bill 397, totally phases out the tax in one-half percent increments with elimination scheduled June 30, 1999.

Medicaid Reimbursement Increase

Effective July 15, 1996, reimbursement for Kentucky physician service to Medicaid patients increased \$26 million. The increase is a result of negotiations between the Patton/Henry Administration and the KMA.

KMA Medicaid Lawsuit

KMA's lawsuit relating to the Jones/Childers \$52 million reduction in physician Medicaid payments is in the process of being settled. Final settlement is expected to get

underway once HCFA grants approval.

Regional Health Care Partnerships

On July 10, 1996, KMA presented testimony at a public hearing in Frankfort regarding the proposed regional health care partnership. The hearing and resulted testimony is expected to become the basis for contracts with partnerships which will provide service to Medicaid recipients on a capitated comprehensive risk basis. The Commonwealth of Kentucky has been granted a special waiver by HCFA to develop the partnerships and deliver Medicaid services on a regional basis.

Data Collection/Practice Parameters

KMA President **Danny Clark, MD**, and staff recently met with Secretary John Morse and Commissioner Rice Leach, MD, regarding data collection requirements under SD 343 and future development of practice parameters. The KMA has been assured by the Administration and by comments from leadership of the General Assembly that physician offices should not be the source for medical data collection. In addition, SB 343 clearly rejected the section relating to development of practice parameters by the Commonwealth. Dr Clark will be serving on a committee to review these and other matters relating to SB 343 as enacted by the 1996 General Assembly.

Local Health Departments' Resources on Risk Assessment Screening by Kentucky Physicians

The KMA Committee on Maternal and Neonatal Health has learned of several materials and services available through local health departments in providing care for women and children. These include counseling and publications for use in HIV screening, such as:

- Personal Risk Assessment — MCH262
- Who Should Be Tested — MCH263
- General patient information sheet on HIV and AIDS
- Information on what every woman who could be (become) pregnant should know ("For Baby's Sake") — MCH261

Another service available in the public health arena is Kentucky's Early Intervention System, which provides screening and testing for children with delayed development.

The Committee encourages Kentucky physicians to contact their local health departments if they wish to explore these and other available services.

Smoking Cessation Guideline

According to the Department of Health and Human Services, 420,000 people die each year from smoking-related illnesses — more than a thousand deaths a day. Smoking is the single greatest preventable cause of sickness and death in the United States. Although more than 70% of adults who smoke say they want to quit, less than half report ever being urged to do so by their doctors.

A new clinical practice guideline issued by the Agency for Health Care Policy and Research (AHCPR) offers help to clinicians to assist patients. The guideline challenges all clinicians to find out if their patients smoke, repeatedly encourage them to quit, and recommend proven treatments.

To order copies of the quick reference or consumer guides, call 1-800/358-9295. To purchase the clinical practice guideline, call 1-202/512-8100.

AMA Physician Practice Sales Publication

The American Medical Association has published the document "Physician Practice Sales: What Every Physician Should Know" by Michael Anthony, JD, and Michael Besny, JD.

In the current health care environment, many physicians are being approached by single or multispecialty physician clinics, hospital systems, insurers, proprietary management companies, and other health care providers seeking to acquire physician practices and employ physicians.

This document highlights the various issues and elements a physician should consider in deciding whether to sell his or her practice and accept employment. It can be ordered free of charge by contacting the Kentucky Medical Association at 502/426-6200.

Breathitt

Myrna Orbana, MD —IM
PO Box 49, Jackson 41339
1984, West Visayas State College,
Philippines

Clay

Craig H. Leicht, MD —AN
401 Memorial Dr, Manchester 40962
1982, Loma Linda, California

Daviess

Robert Halterman, DO —OBG
1215 Main St, Hartford 42347
1988, U of Health Sciences,
Kansas City

Graves

Gregory L. Jones, MD —FP
1116 Links Ln, Mayfield 42066
1980, Medical College of Georgia

Henderson

Cathy L. Freeman, MD —PTH
8033 Woodland Dr, Newburgh, IN
47630
1989, Indiana U, Indianapolis

Hopkins

Viorel C. Raducan, MD —ORS
200 Clinic Dr, Madisonville 42431
1985, U of Montreal

Hardin

Kamal Moulana, MD —PUD
914 N Dixie, Ste 302, Elizabethtown
42701
1980, Rangaraya, India

Jefferson

Naveed M. Chowhan, MD —ONC
1919 State St, Ste 440, New Albany, IN
47150
1082, CETEC, Dominican Republic
Lourdes C. Corman, MD —IM
2403 Medbury Ct, Louisville 40242
1970, Medical College of Pennsylvania
Daniel F. Danzl, MD —EM
530 S Jackson St, Louisville 40292
1976, Ohio State U

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Barren

John M. Smith, MD —R
107 Reed Ave, Glasgow 42141-3236
1985, U of Louisville
William J. Travis, MD —IM
1330 N Race St, Glasgow 42141
1983, Vanderbilt

Boyd

Imtiaz U. Kazi, MD —FP
1 The Oaks Dr, Ashland 41101
1977, Dacca Medical College,
Bangladesh
Samuel G. Welch, MD —P
2200 Lexington Ave, Ashland 41101
1991, U of Kentucky

Leon H. Kircik, MD —D

6400 Dutchmans Pky, Ste 345,
Louisville 40205

1989, State U of New York at Brooklyn

Alexander H. Moore, MD —IM

6110 Fox Cove Court, Prospect 40059
1981, U of Louisville

Kevin M. O'Keefe, MD —AN

4000 Kresge Way, Dept AN, Louisville
40207

1990, U of Colorado

Angelito L. Samson, MD —PD

2424 Boulevard Napoleon, Louisville
40205

1982, Lyceum-Northwestern U,
Philippines

Johnson**Kenneth L. Jones, MD —S**

1000 S Mayo Trl, Paintsville 41240
1978, Howard U, District of Columbia

Knott**Robert C. Brandon, MD —FP**

PO Box 509, Hindman 41822
1980, U of Illinois

Laurel**Esther U. Browne, MD —IM**

310 E 9th St, London 40741
1987, U of Health Sciences, Antigua,
West Indies

Madison**Cathy L. Roberts, MD —AN**

302 Barnes Mill Rd, Richmond
40475-2208

1990, U of Oklahoma

Montgomery**Rhonda G. Grissom, MD —R**

250 Foxglove Dr, Ste 4, Mt Sterling
40353-9770

1990, U of Kansas, Lawrence,
Kansas City

Owen**Jafar Mahmood, MD —IM**

330 Roland Ave, Owenton 40359
1984, Dow, Pakistan

Perry**Jyotin V. Chandarana, MD —NEP**

215 W Argyle Cir, Hazard 41701-9432
1977, U of Baroda, India

Pike**Mary Jo Ratliff, MD —AN**

911 S Bypass Rd, Pikeville 41501
1990, U of Kentucky

Rakesh S. Sachdeva, MD —PD

534 S Mayo Trl, Ste 302, Pikeville
41501-1575

1986, B.J. Medical College, India

Rowan**Marguerite Sellitti, MD —R**

228 W 2nd St, Morehead 40351
1988, State U of New York at
Stony Brook

Trigg**Ronald W. Collins, MD —FP**

331 Pollard Cr, Cadiz 42211
1982, U of Western Ontario

Warren**Julia C. Longo, MD —PTH**

Greenview Hospital — Pathology,
Bowling Green 42104
1986, U of California, LaJolla

Whitley**Pramod A. Reddy, MD —C**

1707 18th St 1-B, Corbin 40701
1980, Osmania, India

In-Training**Kenton****Fred W. Dunaway, MD —FP****Jefferson****Kittie W. George, MD —ORS****Thomas C. Hubbs, MD —PD****Amy M. McNeal, MD —FP****Daniel C. Sim, MD —FP****Stuart W. White, MD —PD****DEATHS****Robert S. Dyer, MD**

Louisville

1915-1996

Robert S. Dyer, MD, a retired internist, died June 14, 1996. Dr Dyer graduated from the University of Louisville School of Medicine in 1940 and was a life member of KMA.

James D. Evans, MD

Pikeville

1919-1996

James D. Evans, MD, a retired internist, died June 21, 1996. A 1950 graduate of Emory University School of Medicine, Dr Evans was a life member of KMA.

Marie M. Keeling, MD

Louisville

1925-1996

Marie M. Keeling, MD, a retired pathologist, died June 22, 1996. Dr Keeling, a blood specialist, discovered the anemia trigger — what is now called Hemoglobin Louisville, an inherited blood disorder. Later, Dr Keeling helped pioneer a process that allows a person to store his or her own blood for use during a later operation. She was a 1956 graduate of the University of Louisville School of Medicine and a life member of KMA.

Truman W. DeMunbrun, MD

Louisville

1927-1996

Truman W. DeMunbrun, MD, a retired family practitioner, died August 1, 1996. A 1958 graduate of the University of Louisville School of Medicine, Dr DeMunbrun was a life member of KMA.

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19 — Neurology for Primary Care Provider, Radisson Plaza, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323-5161 or FAX 1/606/323-2008.

27-31 — 1996 State-of-the-Art Conference — "Managed Care and Occupational Medicine: the Next Generation," Toronto, Ontario, Canada. Sponsored by the American College of Occupational and Environmental Medicine. Contact: Kay H. Coyne, ACOEM, 55 W Seegers Rd, Arlington Heights, IL 60005-3919; phone 708/228-6850, FAX 708/228-1856.

NOVEMBER

1 — Norton Hospital Cancer Treatment Center Oncology Symposium will present "Multidisciplinary Management of Head & Neck Cancers" — 8:00 am-9:00 pm, Hyatt Regency Louisville. Contact: Alliant Health System CME office, 502-629-8574.

1-3 — Diabetes Conference, New Developments in the Pathogenesis & Treatment of NIDDM (non-insulin dependent diabetes mellitus); Radisson Resort, Scottsdale, AZ; sponsored by the American Diabetes Association of Arizona and the National Institute of Diabetes and Digestive and Kidney Diseases. Contact: American Diabetes Assoc, Arizona Affiliate, Inc, 2328 W Royal Palm Rd, Ste D, Phoenix, AZ 85021; phone 602/995-1515; FAX 602/995-0004.

10-15 — 27th Annual Family Medicine and Primary Care Review, Hyatt Regency, Lexington, KY. Contact: University of Kentucky Office of CME; telephone 1/800/204-6333; 606/323-5161 or FAX 1/606/323-2008.

21-22 — Perinatal/Neonatal Symposium, Lexington, KY. Contact: University of Kentucky Office of CME; 1/800/204-6333; 606/323-5161 or FAX 1/606/323-2008.

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| Baptist Healthcare System | 414 | National Insurance Agency, Inc | 378 |
| Classified | 414 | PIE Mutual Insurance Company | 407 |
| Financial Architects, Inc | 415 | Prime Care Center | 414 |
| HealthFind.com | 382 | Sleep Medicine Research Foundation Inc. .. | 413 |
| Humana Health Care Plans | 406 | Team Health | 415 |
| Intrav | 385 | University Radiological Associates | 377 |
| KY Medical Insurance Company, Inc ... | Cover II | US Army Reserve | 401 |
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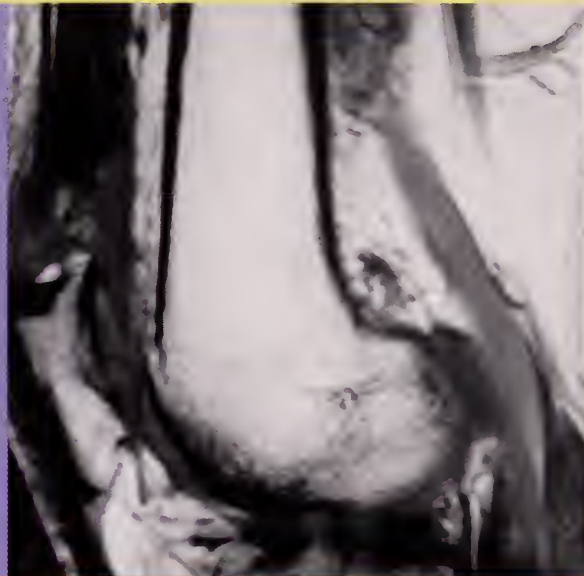


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President 1996-97

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- 12:00–1:00 pm Lunch**
- 1:00–2:00 pm Infectious Diseases Encountered on Medical Mission Trips**
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Rita Browning, MD
- 3:00–4:00 pm **Obstetrics-Gynecology Problems in Developing Countries**
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VOLUME 94, NUMBER 10

OCTOBER 1996

| | | |
|-------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| COVER STORY | Profile — William H. Mitchell, MD, KMA President 1996-97 | 452 |
| SCIENTIFIC | Transmyocardial Revascularization for Intractable Angina <i>Allan M. Lansing, MD, PhD; Surgeet Singh, MD; Joseph A. Lash, MD</i> | 432 |
| SPECIAL ARTICLES | Developing Generalists for Kentucky <i>Amy V. Blue, PhD; Michael B. Donnelly, PhD; Peggy Harrell-Parr, PhD; Amy Murphy-Spencer, EdS; Robert F. Rubeck, PhD; Roy K. Jarecky, EdD</i> | 439 |
| | Geographic Origin and Its Impact on Practice Location in Kentucky <i>Carol L. Elam, EdD; Marcy E. Rosenbaum, PhD; Mitzi M.S. Johnson, PhD</i> | 446 |
| EDITORIAL | The Decline of Civility: The Coarsening of America <i>Jaroslav P. Stulc, MD</i> | 457 |
| ASSOCIATION | <i>Monitoring Medicine</i> | 429 |
| | <i>News</i> | 464 |
| DEPARTMENTS | President's Page | 425 |
| | Advertisers' Guide | 468 |
| | Alliance Page | 461 |
| | Classifieds | 467 |
| | Information for Authors | 436 |
| | Letters to the Editor | 462 |



COVER: On September 28, 1996, William H. Mitchell, MD, a Richmond surgeon, was installed as the 146th President of the Kentucky Medical Association. Dr Mitchell's Inouguorol Address begins on page 425 and a profile of this highly accomplished physician begins on page 452.

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Inaugural Address

William H. Mitchell, MD

What Can We Do Today?



The most important day is today.

Yesterday is past.

No one has ever succeeded in living a better past.

Tomorrow is completely unknown.

All that is past is merely a prologue.

However we got here, we are here now, and facing change.

All of the changes that influence the way physicians practice medicine today have their foundation in past events and past actions. What is more important is that the actions, choices, and decisions we make today will profoundly affect our patients and our profession tomorrow. In the past, we have endeavored to convey to our patients, legislators, and health care planners what the priorities of our health care system should be. For the good of our patients, we must redouble our efforts. Our patients face a changing and uncertain future. We must continue to be their advocates.

Our profession faces changes that threaten to distract us from our primary goal of good patient care. We need to clearly define our priorities.

Our health care system is changing. We have the added responsibility and obligation to develop a detailed understanding of and an involvement in these changes, specifically managed healthcare. We must be patient advocates and also health care planners. We must become knowledgeable about health care delivery systems.

As President of the Kentucky Medical Association, I intend to work with you and your leadership to deal with these changes.

With regard to patient advocacy: As your President, I will work with the KMA to educate our patients about the lethality of tobacco use. The World Health Organization study released in September 1996 indicated that by the year 2020, tobacco-related diseases will become the world's greatest killer.

The KMA will exert its influence to limit irresponsible behavior such as drug and alcohol abuse.

"As physicians we cannot permit ourselves to assume a passive role in the changes that face us. I need your support, your advice, your counsel, and your active involvement in these efforts."

"If the terms 'quality' is defined as: 'The most appropriate care, in the most appropriate setting, at the most appropriate time,' then I accept the definition. This means that the 'value' of a service can be indexed by the quality of the service relative to its cost. But, 'quality' means efficient. It does not mean cheap!"

We will vehemently oppose unrestrained, unprotected and reckless motor vehicle and watercraft activity. The same World Health Organization study indicates that by the year 2020, heart disease, depression, and motor vehicle accidents will overtake infectious diseases to become the world's leading causes of death and disability. Riding in a car without a seatbelt, riding in the open back of a pick-up truck, and riding a motorcycle without a helmet need our sustained public opposition.

We will continue to support efforts to prevent domestic violence and to help its victims. We must support our families. Charles Colson stressed the importance of the family by saying:

"The front line in the war against crime . . . is not in Congress or the courts or even streets patrolled by uniformed troops. It runs through every living room in America, where parents teach their children right from wrong. It runs through every classroom, where teachers pass on a culture's common moral heritage. It runs through every film and movie, where virtue is either mocked or praised. A society cannot survive if the demands of human dignity are not written on our hearts from early childhood."

We will continue to educate our patients about the dangers of sexually transmitted diseases and work for AIDS prevention.

We will continue to work with our colleges, universities, and medical schools to produce competent, caring, and committed physicians.

These are our priorities. These are things doctors care about. These are the things we are supposed to be doing, and we mean to continue to do them.

With regard to managed care: We must adapt. We must understand, in practical terms, what "managed care" means. We

must get the facts straight. Understanding managed care will require a focused educational effort on the part of every Kentucky physician.

The Kentucky Medical Association, recognizing the need for Kentucky physicians to have a voice in these managed care changes, will meet this challenge. The 1996 member survey to determine interest in forming a physician-owned and directed managed care organization resulted in 92% of the respondents (Y-1552/N-140) supporting such an undertaking.

This proposal will be before the House of Delegates tonight.

I will support this if it can be accomplished in a manner that will allow Kentucky physicians to have a strong voice in quality matters. I will support this if it leads to reimbursing every Kentucky physician the same amount for the same service. I will oppose any differential payment system based on geographic location.

Physicians and health planners agree that quality patient care is the primary goal.

If the term "quality" is defined as: "The most appropriate care, in the most appropriate setting, at the most appropriate time," then I accept the definition. This means that the "value" of a service can be indexed by the quality of the service relative to its cost. But, "quality" means efficient. It does not mean cheap!

We need to stress the concept of "efficiency." Efficiency means reaching the goal with the least expenditure of waste, expense, or resources. The most efficient method may not be the least expensive.

This concept will be of increasing importance as capitated reimbursement arrangements proliferate. "Capitation" is a payment system in which physicians are paid a fixed amount of money per member per month. This payment is made no matter what medical resources are

utilized. We need to insure that the proper quality monitoring mechanisms are in place to prevent under utilization of necessary services. We must become directly involved in this process.

One of the essential elements of a managed care relationship is the contract between the physician and the insurance company. A contract is "an agreement or covenant between two or more parties, in which each binds itself to do or forebear some act, and each acquires a right to do what the other promises: A mutual promise upon lawful consideration or cause which binds the parties to a performance; a bargain; a compact."

Any physician who participates in a managed care relationship does so through the execution of a contract. The assumption is made that this contract is entered into voluntarily.

If any individual or group of

"It is not apathy that afflicts most physicians. It is simply a paralysis of action in the face of a complex set of fears and anxieties."

physicians feels that a contract is unfair, unjust, or unethical, then they may cancel the contract.

As physicians we cannot permit ourselves to assume a passive role in the changes that face us. I need your support, your advice, your counsel, and your active involvement in these efforts.

In our effort to develop a managed care entity, we must not allow ourselves to become what we fear. A huge network of anxieties pervades our thinking and threatens to influence our behavior. It is not apathy that afflicts most physicians. It is simply a paralysis of action in the face of a complex set of fears and anxieties. We must not permit our adversaries to determine our actions. We must follow a course that charts itself to the best interests of our patients.

Presented by
William H. Mitchell, MD
as he assumed the
Presidency of the
Kentucky Medical Association
on September 28, 1996



While you're looking out for your patients, who's looking out for you?

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As **advocate** for patients and the medical profession in health insurance reform, the AMA had the advantage of **a special brand of know-how**

What most people know about major legislation often boils down to the one or two provisions that draw the most media attention. That's certainly the case with the just-passed health insurance reform bill.

Your patients are most likely to be aware that their employer-based insurance now is portable as they move from job to job and that they won't be denied insurance for preexisting conditions. The more knowledgeable among them will understand and welcome the provision that allows medical savings accounts to prove their value in the marketplace.

The AMA was an early and strong advocate for these important reforms. It based its support on its understanding of the problems and opportunities in health care, its knowledge about what can be realistically accomplished, and its ability to do what's necessary to achieve those goals.

The AMA also applied that special brand of know-how to a critically important part of the same legislative package that received far less attention — the fraud and abuse provisions.

The AMA opposes fraud and abuse in the health care system. It believes that those who have set out to cheat the system should be punished. But the AMA also knows that the answer to the problem is not to turn enforcement into a legal and professional nightmare for honest physicians, and not to treat innocent paperwork mistakes as criminal acts. There was a chance that could happen if certain language had been adopted in the final version of the bill.

The AMA understood that the heart of the problem was a legal distinction about criminal

intent. Under the bill proposed by the Senate — and ultimately passed — physicians will be subject to criminal penalties only for "knowing and willful" fraud and abuse violations. The AMA strongly supported that essential language. The original House bill did not take into account the intent to do wrong. And that was simply not appropriate in a field like medicine, where subjective judgment calls are demanded every day.

In making its case, the AMA needed to determine realistically what could be achieved. Firing broadsides at the fraud and abuse provisions in hopes of sinking them, as some critics did, would have been a losing strategy. Both political parties had long been enamored of the provisions and were not about to drop them from a final bill.

Instead, the AMA went about the work of achieving an appropriate and realistic goal — to get the right language adopted in the final bill. And the AMA knew how to get that job done.

From early on, the AMA had conducted a quiet campaign to educate lawmakers about organized medicine's concerns and the legal distinctions involved. When the time was right, it got physicians involved in grass-roots lobbying. Twice in early June, the AMA sent 70,000 faxes to members of its Physicians Grassroots Network — member physicians who are interested in making their voices heard on key legislative issues.

The AMA provided those members with access to the lawmakers' offices via a toll-free hot line. All told, 4,000 connections were made. Moreover, improvements to the hot line

KMA

system allowed the AMA's Washington, D.C. office to track which offices were reached — 372 from the House and 94 from the Senate — and how many calls were made to each individual lawmaker. When AMA lobbyists then went to visit, they had the advantage of knowing how many constituents that particular lawmaker had already heard from.

Due in very large part to the AMA's efforts, that essential "knowing and willful" language was included in the final version of the

bill. Similar wording was adopted for civil monetary penalties for Medicare and Medicaid fraud and abuse. President Clinton has said he will sign the legislation.

Also in the final legislation is a provision, lobbied for heavily by the AMA, that would give physicians the right to obtain an advisory opinion from the government *before* they undertake specific practice arrangements. Regrettably, lawmakers stipulated that the advisory provisions expire after a four-year period. Still, in an area as

complex as government regulation, any protection from bureaucratic second-guessing is welcome.

It may not be the stuff of headlines, but these changes — and the effectiveness of organized medicine in advocating for them — are very good news for physicians.

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This month, **Seyhan O. Senler, M.D.**, presents the following case:



Figure A

This eleven-year old male presented with intermittent submassive hemoptysis of unknown etiology. Bronchoscopic evaluation localized the bleeding to the right lung.

Selective right-sided bronchial arteriography revealed numerous areas of extravasation throughout much of the right bronchial distribution (Figure A).



Figure B

Following superselective microcatheter embolization, there was prompt cessation of hemoptysis (Figure B). The patient recovered without recurrence. Although a precise etiology was not found, it was thought to be post-inflammatory in nature.

Transmyocardial Revascularization for Intractable Angina

Allan M. Lansing, MD, PhD; Surgeet Singh, MD; Joseph A. Lash, MD

From The Heart Institute, Columbia Hospital Audubon, One Audubon Plaza Drive, Louisville, KY 40217. Dr Lansing is Director of The Heart Institute.

Advances in medication, angioplasty and coronary bypass graft have produced relief of symptoms and prolongation of life for many patients with coronary artery disease. There remains, however, a group of patients with intractable angina that has been resistant to all forms of therapy except for the radical step of heart transplantation. Surgeons have tried indirect methods of revascularization for years beginning with Beck¹ and Vineberg.² It was known that reptiles have no coronary arteries and obtain the blood supply for the myocardium through channels arising directly from the lumen of the left ventricle. Mirhoseini³ began animal experiments in 1970 to reduplicate this circulation. Finally, using a carbon dioxide laser, he was able to produce channels that remained patent, became lined with endothelium, and made connection with the intramyocardial vessels.⁴ The first human patient was operated upon by Crew in January 1990.⁵ At first the procedures were performed along with coronary bypass graft under hypothermia with cardiac arrest, the laser being employed in areas that could not be revascularized directly. Recently a more powerful laser (PLC Medical Systems, Inc) became available that can be fired from the epicardial surface of the heart into the interior of the ventricle in a single pulse lasting .05 seconds. This is timed to the electrocardiogram so the laser shot is fired just after the peak of the R-wave, at which time the heart is full, still, and totally refractory to any stimulus. As a result the heart does not need to be arrested, cardiopulmonary bypass is not required, and no arrhythmia occurs.

The investigation of this therapy is under FDA supervision and is monitored by the Institutional Review Board of the hospital. An extensive informed consent approved by the FDA and IRB is obtained from each patient. Our institution was approved for participation in this investigation

and we began treatment of patients in February 1994. This report will summarize the indications, results, and observations in the management of the first 75 patients operated upon in this series.

Patient Selection

All patients had Class IV angina (Canadian classification) and had exhausted all attempts at treatment by medication, angioplasty, and coronary bypass grafting. Patients with only congestive heart failure as the primary complaint were not selected. Thirty-three of the patients had undergone one or more PTCA procedures, and one or more coronary bypass operations had been performed in 59. Ten patients had received medication only, 9 because of small diffusely diseased vessels and 1 woman with Syndrome X. Of the 75 patients, 60 were males and 15 females. Their ages ranged from 35 to 83 years with a mean of 63. Twenty-nine of the patients were operated upon electively at the beginning of the study, and then the rules were changed by the FDA. Subsequently 16 patients have been control patients followed for 3 or more months before TMR, 5 have been compassionate cases done because of severe angina and not followed for 3 months, and 25 underwent an emergency operation because of an unstable condition that confined them to a Coronary Care Unit on intravenous heparin and nitroglycerin. Twenty-five patients had a previous internal mammary artery graft, 20 of which were widely patent, 2 occluded, and 3 were stenotic. In spite of patency the 20 patients continued to have Class IV angina. Three patients were scheduled for heart transplant in other centers, 1 patient had heparin allergy and a previous coronary bypass graft, 1 had Syndrome X, and 1 was a Jehovah's Witness patient who faced a difficult reoperation coronary bypass graft. Patients were excluded if they had some other disease with a

short life expectancy, sepsis, severe heart failure, a high risk for general anesthesia, or advanced emphysema.

The preoperative assessment of the patient included a list of all the cardiac medications, the results of cardiac catheterization, estimation of the left ventricular ejection fraction by echocardiogram or MUGA, and a stress thallium unless the patient was very unstable in which case only a resting thallium was obtained. Follow-up studies at 3, 6, and 12 months were undertaken including ejection fraction, stress thallium, angina class, and medications.

Procedure

Under general anesthesia, a left anterior thoracotomy incision was made through the fifth intercostal space. The lung was packed posteriorly and the pericardium opened to expose the heart. In most cases the patient had undergone one or more coronary bypass graft operations, and adhesions had to be carefully divided to expose the left ventricle. The areas of ischemia to be targeted were determined by the results of coronary arteriography and thallium studies. A transesophageal echocardiogram probe was in position when the laser was fired with a power of 40 to 70 joules to penetrate the left ventricular wall. Successful entrance to the ventricular cavity was confirmed by a burst of bubbles seen on the TEE. The holes were placed about one centimeter apart and 20 to 39 holes were drilled depending on the area of ischemia and the size of the heart. Bleeding was controlled by finger pressure and only occasionally was it necessary to suture the epicardial opening. Drainage tubes were inserted, the incision closed, and the patient returned to the Intensive Care Unit for 24 to 36 hours. Ambulation was begun and the patient discharged when he was comfortable and the incision appeared to be healing well. In the postoperative period all of the patient's cardiac medications were resumed the next day and continued for 2 months, after which gradual withdrawal was undertaken.

Observations

The preoperative ejection fraction ranged from 15% to 75% with a mean of 45%. The preoperative thallium indicated stress ischemia in all patients in whom a treadmill exercise test could be performed or persantine injected. Eleven patients with very unstable angina or on continuous intra-

Table 1. TMR Hospital Complications (75 patients)

| | |
|--------------------------------------------|----|
| Bleeding | 2 |
| AMI | 3 |
| Arrhythmia | 7 |
| CHF | 2 |
| Transfusion | 12 |
| Atelectasis | 3 |
| Stress Ulcer | 1 |
| Mitral Regurgitation (Ruptured Chordae) | 1 |
| Death | 5 |

venous nitroglycerin could only undergo a resting thallium study. A reversible segment of ischemia was found in only 42 of the 64 patients who underwent stress studies. The postoperative stay ranged from 0 to 17 days, including one patient with an ejection fraction of 15% who died on the first day. The mean postoperative stay was 6.9 days.

The in-hospital complications are listed in Table 1. Postoperative bleeding requiring reexploration and suture of one of the holes occurred twice in the first 15 patients but has not happened since. Acute myocardial infarction occurred early in the postoperative period in three patients, leading to two deaths. Both of these patients were very unstable at the time of operation and this result led to a change in our protocol to include immediate anticoagulation postoperatively to prevent this complication, which has subsequently not occurred. Arrhythmias were controlled medically and were not life threatening, and transfusion has been required in 12 patients. Although the contractility of the left ventricle did not appear to change during the procedure, as confirmed by the TEE, many of the patients had pulmonary congestion when they reached the recovery room and hence diuretic therapy was instituted. Congestive heart failure was observed early in the series, but once again prophylactic diuretic therapy has reduced the incidence of this problem. One patient developed mitral regurgitation 36 hours after operation and was subsequently found to have rupture of two adjacent chordae tendineae, which had apparently been lying against the ventricular wall and were partially injured by the laser shot. Repair of the mitral valve was required 5 days later, and fortunately the patient remains free of mitral regurgitation and angina 6 months later.

There were five in-hospital deaths among the 75 patients. Two of the patients had an initial

Transmyocardial Revascularization for Intractable Angina

Table 2. TMR Post-Op Hospital Admissions (75 patients)

| | |
|-------------|---|
| AMI | 1 |
| Chest Pain | 6 |
| CHF | 8 |
| Arrhythmia | 2 |
| Non-Cardiac | 6 |
| Death | 1 |

Table 3. TMR Post-Op Angina Class

| | 3 months | 6 months | 9-12 months |
|-----|----------|----------|-------------|
| 0 | 2 | 8 | 5 |
| I | 10 | 8 | 5 |
| II | 9 | 3 | 0 |
| III | 5 | 4 | 1 |
| IV | 2 | 1 | 0 |

ejection fraction of 15% to 20% and were operated upon because of severe angina, but each developed a low cardiac output syndrome in the postoperative period and did not survive. Two other patients were those with very unstable electrocardiograms who suffered myocardial infarctions in the early postoperative period. There was only one unexpected death, a patient with a preoperative ejection fraction of 45%. However, he had suffered a recent preoperative myocardial infarction, had chest pain all night before operation, and had an ongoing myocardial infarction that was not favorably affected by the procedure. This patient subsequently developed a low cardiac output syndrome and died in spite of supportive measures.

Follow-Up

The postoperative hospital admissions in these 75 patients are listed in Table 2. One patient suffered an acute myocardial infarction but survived and has had no further angina. Eight admissions were for congestive heart failure early in the series before we instituted prophylactic diuretic therapy for 1 month in all patients. There was one death 2 months after operation in a patient who had poor ventricular function and ventricular arrhythmias preoperatively as well as severe angina. His ejection fraction deteriorated from 34% to 20% in the 2 weeks before operation, but he survived and never had any further angina. However, the

arrhythmias and heart failure persisted and eventually led to his death. Most of the admissions for chest pain were musculoskeletal in nature and admissions for arrhythmia occurred in patients in which it was present preoperatively and these were controlled medically.

There were two patients in this series who crossed over to a coronary bypass graft. In one patient TMR had been selected because the patient had undergone laryngectomy and bilateral radical neck dissection and the surgeon was concerned about the risk of mediastinal infection if a sternotomy were performed in the presence of the permanent tracheostomy. Four months later he continued to have persistent unstable angina and underwent a triple coronary bypass graft and has subsequently done well. The second patient had a history of depression and continued to have severe pain in spite of a stable ejection fraction and a thallium study that showed improved perfusion 6 months later. He refused further studies and did undergo a third coronary bypass graft 1 year after TMR, and at the present time states that his angina has been improved. These represent the only two failures in the group.

The angina status of the patients at present is listed in Table 3. Fifteen of the patients have no angina, 23 are Class I meaning that only severe exertion brings on angina, and another 12 are Class II at the present time. Thus by 3 months 75% of the patients have no angina or are Class I or II, by 6 months it is almost 80%, and by 1 year it is over 90%.

The results of the thallium studies are shown in Table 4 and these indicate in 3 months the perfusion has been improved in almost half the patients and that at 6 months it is improved in 71% of the patients. We have had some difficulty in getting stress thallium studies repeated by the cardiologists in other centers outside the immediate area, particularly when the patients are doing well, but we are working hard to complete these studies in order to comply with the protocol of the investigation.

The ejection fraction at 3, 6, and 12 months is illustrated in Table 5, and this shows that there is rarely any significant change in the ejection fraction following TMR. Areas of scar tissue in the damaged myocardium are not improved by TMR and the muscle appears to be responding as well as it can preoperatively so that the contractility does not increase even though angina has been reduced or eliminated.

The patients with unusual indications for

TMR have also done well in follow-up. The Jehovah's Witness patient who was selected to avoid a reoperation coronary bypass graft is Class I at 9 months, and the heparin allergy patient is Class II at 6 months. All three heart transplant candidates are Class I, 2 to 6 months after TMR. The Syndrome X patient is Class I from an angina standpoint, but does complain of fatigue and is presently enrolled in cardiac rehabilitation. She has not been readmitted to the hospital in spite of the fact that she required monthly hospital admissions for prolonged pain and EKG changes before TMR.

Although the patients stayed on their antianginal medication for the first 2 months, there was a gradual reduction after this period. Preoperatively the patients on an average were taking three different cardiac medications plus nitroglycerin, at 3 months two drugs, and at 6 months they averaged 1.4 antianginal medications.

Discussion

The patients selected for this series all had Class IV angina and had exhausted all forms of medication, PTCA, and coronary bypass grafting. In spite of this about 75% of the patients had no angina or were Class I or II by 3 months, 80% by 6 months, and over 90% by 1 year. At the same time their requirement for cardiac medication steadily decreased.

The operative mortality was 6.7%, but should be significantly less in the future on the basis of our experience. We would no longer have accepted the first two patients who died because of a low preoperative ejection fraction; and since the death of another two unstable patients from myocardial infarction in the early postoperative period, we have used prophylactic anticoagulation beginning the day of operation. Since then no other unstable patients have suffered this fatal complication. The fifth death occurred in a patient who had an ongoing acute myocardial infarction at the time of operation.

The observation of occasional severe pulmonary congestion in the first day led us to institute a regimen of dobutamine for 24 hours and daily diuretics for 1 month. The etiology is probably increased stiffness of the left ventricle as a result of hemorrhage within the myocardial tissue. The compliance of the ventricle is decreased and hence the filling is impaired and pulmonary congestion occurs. This same phenomenon and our experience with patients with very low ejection

Table 4. TMR Stress Thallium

| | 3 months | 6 months | 12 months |
|--------|----------|----------|-----------|
| Better | 20 | 22 | 4 |
| Same | 21 | 9 | 5 |
| Worse | 2 | 1 | 0 |

Table 5. TMR Ejection Fraction

| | 3 months | 6 months | 12 months |
|--------|----------|----------|-----------|
| Better | 6 | 2 | 2 |
| Same | 22 | 19 | 11 |
| Worse | 3 | 4 | 2 |

fractions has led us to restrict the operation to patients with an ejection fraction of 25% to 30% at least.

The thallium studies have not been very helpful in selecting patients for operation since a non-reversible segment of ischemia may appear to have completely normal myocardium at the time of operation, and follow-up studies show a gradual improvement with appearance of reversibility and occasionally a completely normal thallium uptake. We do use a thallium to indicate areas of ischemia that we might not have suspected on the basis of the coronary arteriogram alone.

As far as ventricular function is concerned, the ejection fraction is usually unchanged in the follow-up period, but occasionally a few patients have demonstrated decreased function compared to preoperatively. In these cases, progression of the native coronary disease may have occurred with further scarring of the ventricle. Similarly, ventricular arrhythmias and congestive heart failure preoperatively were not improved by TMR.

Our series included 20 patients with a widely patent internal mammary artery graft, but they still had Class IV angina. Areas of the lateral and inferior wall of the left ventricle remained ischemic and were the source of angina, but in one of the patients the ischemia was also located anteriorly in spite of a widely patent graft. Perhaps blood was being stolen from this area in the heart's effort to provide blood supply to other areas of the myocardium.

Some of the patients have a dramatic relief of angina within the first week, but in most cases there is a gradual improvement of the angina sta-

Transmyocardial Revascularization for Intractable Angina

tus. This may indicate the creation of a reptilian type of circulation, or it may be the development of more bridges between the laser channels and intramyocardial collateral channels. Finally, the laser channels may also be the stimulus for the development of neovascular channels.

We started with 75 patients, and had 5 operative deaths and 1 late death leaving us with 69 patients. Two of these crossed over to a subsequent coronary bypass graft, giving us 67 patients whom we are presently following. Further operations will be carried out under a protocol for a random series comparing further medical treatment with TMR as required by the FDA.

Addendum

Since this report was accepted, the series has increased to 192 patients who have undergone TMR, 140 with the CO₂ laser, and 52 with a Holmium-YAG laser. The relief of angina remains the same: by 3 months two-thirds of the patients are class O, I or II, by 6 months 75%, and by one year almost 90%. The mortality with the CO₂ laser for elective cases is now 2.6%, and for unstable (preinfarction) angina is 12%. A randomized control series comparing TMR to continued medical therapy is underway.

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References

1. Beck CS. The development of a new blood supply to the heart by operation. *Ann Surg.* 1935;102:801-813.
2. Vineberg AM. Clinical and experimental studies in the treatment of coronary artery insufficiency by internal mammary artery implant. *J Int Coll Surg.* 1954;34:257.
3. Mirhoseini M, Cayton MM. Revascularization of the heart by laser. *J Microvasc Surg.* 1981;2:253.
4. Mirhoseini M, Shelgikar S, Cayton MM. New concepts in revascularization of the myocardium. *Ann Thorac Surg.* 1988;45:415-420.
5. Crew J. Seton Medical Center, San Francisco (personal communication).

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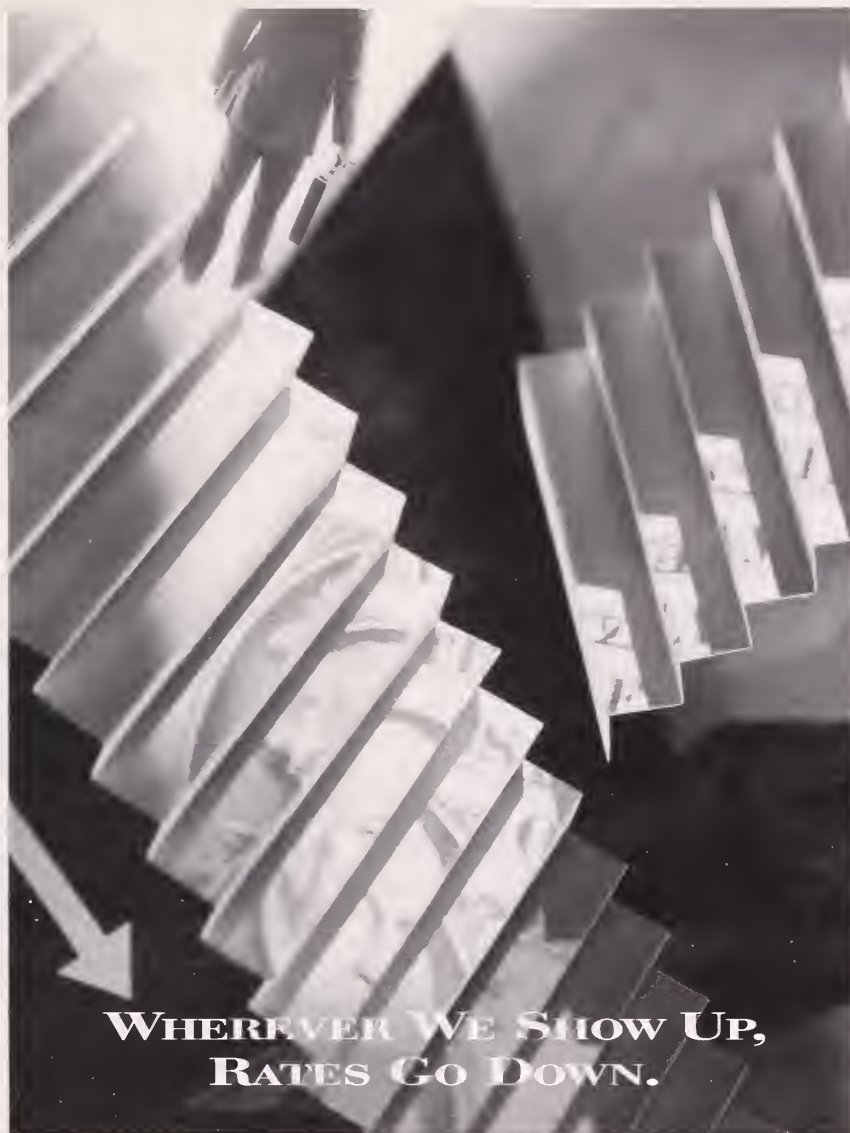
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Developing Generalists for Kentucky

Amy V. Blue, PhD; Michael B. Donnelly, PhD; Peggy Harrell-Parr, PhD; Amy Murphy-Spencer, EdS;
Robert F. Rubeck, PhD; Roy K. Jarecky, EdD

Since 1985, nearly half of the graduates of the University of Kentucky College of Medicine have chosen generalist careers, even though its students received almost no outpatient ambulatory training in primary care before 1990. This study determined the factors influencing the choice of generalist specialties in the absence of ambulatory training experience.

A questionnaire was mailed to the 516 graduates of the classes of 1964 through 1989 who had entered a generalist specialty. A three-way ANOVA with one repeated measure was used to determine whether there were statistically significant differences in the responses of practitioners in the three generalist specialties (family practice, general internal medicine, or general pediatrics).

Sufficiently complete responses were received from 187 graduates (116 family practitioners, 40 general pediatricians, and 31 general internists). Many of the physicians who had spent formative years in rural areas were practicing in rural communities. Many respondents had already decided upon a generalist career before entering medical school. Clerkships in internal medicine and pediatrics were an important influence, as was mentor role modeling. For pediatricians, an elective ambulatory care experience was also important.

Educational experiences exert meaningful influences on students interested in a generalist career. Formal ambulatory care training experiences, while not critical for the selection of a generalist career, may heighten or confirm interest. Efforts that encourage students from rural communities to enter medical school appear to produce rural physicians.

Experts in health care staffing and policy have expressed widespread concern about the fact that fewer medical students each year are pursuing careers as generalists. Recent reports indicate that the number of graduates entering the generalist fields of family practice, internal medi-

cine, and pediatrics has declined.¹ Several factors reportedly contribute to students' specialty choices and, subsequently, to their shifts in specialty preference. These factors include personal variables, the projected income of a specialist in a particular field, indebtedness from educational loans, lifestyle factors, the technological and methodological characteristics of the specialty, academic performance, and medical experiences as an undergraduate.²⁻⁷ Students' interest in choosing generalist specialties may increase if they are exposed to the principles of primary care during their undergraduate education. According to a 1991-92 curriculum survey by the American Association of Medical Colleges (AAMC), only approximately 17% of US medical schools require training in primary care for third-year medical students.⁸

The University of Kentucky College of Medicine (UKCOM) was established 35 years ago to provide physicians for the Commonwealth of Kentucky. The need for generalist physicians in Kentucky is great. UKCOM has focused on meeting this need; in a 1995 listing of the best primary care schools in the United States UKCOM ranked third.⁹ Since 1985, almost 50% of the graduates of UKCOM have opted for a generalist specialty (Roy Jarecky, personal communication to the Dean). This statistic is interesting because before the implementation of a required third-year ambulatory Primary Care Clerkship in the fall of 1990, UKCOM students received almost no outpatient ambulatory training in primary care.

To determine the factors influencing the choice of generalist specialties when a required ambulatory training experience was absent from the curriculum, we examined the personal and educational factors associated with the selection of generalist practice by UKCOM students who graduated before the fall of 1990. This information should be useful to medical educators and curriculum planners in determining the influence of educational experiences on the selection of a generalist career, and the scope of such experi-

From the University of Kentucky College of Medicine, Lexington, KY, and the Department of Surgery and Office of Academic Affairs, University of Kentucky (Dr Blue).

Developing Generalists for Kentucky

ences. The decision to examine the selection of a generalist career in light of the absence of this educational experience was made in part to assess the role of educational experiences on specialty selection, and to control, in part, the attribution bias common to many studies of specialty choice.¹⁰

Methods

For the purposes of this study, generalist specialties were identified as family practice (FP), general internal medicine (IM), and general pediatrics (GP). In April 1992, a five-page questionnaire was mailed to all 516 graduates of the UKCOM classes of 1964 through 1989 who had entered a generalist specialty (family practice, general pediatrics, general internal medicine, and general practice). Members of the graduating class of 1990 were excluded because class members who were still in residency training would not be able to assess their satisfaction with specialty choice. The exclusion of the graduating classes of 1990 and 1991 also permitted us to assess the influences of specialty choice in the absence of a required ambulatory training experience in the third year of medical school. In June 1992 the questionnaire was mailed a second time to follow up on non-respondents.

The questionnaire solicited information about current specialty practice, the types and sizes of the communities in which the respondent had spent formative years and in which the respondent currently lived and practiced medicine, the percent of time spent in various work activities (ie, clinical care, research, teaching, etc), whether the respondent would enter a generalist specialty again, when the generalist career choice had been made, current satisfaction with the career choice, critical influences on the decision for a generalist career, and lifestyle factors related to the choice of a generalist specialty. Critical experiences influencing the decision to enter a generalist career were measured on a five-point scale (0 = not a factor, 4 = a critical factor); lifestyle factors related to the choice of a generalist specialty were also measured on a five-point scale (0 = not important; 4 = critically important).

The data obtained from the generalist specialty graduates who responded to the questionnaire were analyzed, and descriptive statistics were obtained for all items. A three-way analysis of variance (ANOVA) with one repeated measure was used to determine whether there were statisti-

cally significant differences among the three generalist specialties (FP, IM, or GP), urban versus rural practitioners, or the interaction of these two factor items in how they responded to (1) critical influences items and (2) lifestyle factor items (each used as the repeated measure). Analyses of simple effects and Fisher's PLSD post hoc test were used to explore statistically significant interactions among the variables.

Results

One hundred eighty-seven of the 516 graduates (36%) provided sufficiently complete information to be included in the study. Of these respondents, 116 (62%) were family practitioners, 40 (21%) were general pediatricians, and 31 (17%) were general internists. One hundred thirty-eight (74%) of the respondents were men. For the purposes of simplifying the data analyses, the responses to the questions related to the community size of the physicians' formative and practice years were both recoded to (1) rural area (defined as towns less than 10,000 in population) or (2) urban area (defined as towns greater than 10,000 in population). Fifty-four percent of the physicians were from urban areas. Of these, 81% practiced in the larger urban areas. Of those coming from rural areas (46% of the total sample), 56% practiced in rural areas. The association between formative community and practice community was .38 (Pearson correlation, $p < 0.0001$).

On average, the respondents devoted 85% of their time to providing clinical care. Sixty-six percent of respondents indicated that they would enter their present generalist specialty again, 12% indicated they would change specialties, 5% indicated they would not enter a generalist specialty, and 6% indicated they would not enter medical school again (11% did not respond to this question). Seventy-six percent of respondents were very satisfied with their careers, 9% were somewhat satisfied, and 10% were somewhat to very dissatisfied (5% did not respond). No significant differences existed between the three generalist specialties on practitioners' overall satisfaction with their career choices ($p = 0.0236$).

Overall, 93% of the respondents entered primary care directly from a residency or fellowship program, 43% decided to pursue a generalist specialty before entering medical school, and 38% made the decision during the last 2 years of medical school. Of the critical experiences, including those in medical school, that led to the selection

UNIVERSITY OF KENTUCKY COLLEGE OF MEDICINE

Selection of Primary Care as a Career Choice

Form PC

1. Name: (Please Print) _____
2. UKCM Graduating Class: _____
3. Practice Address: _____
4. Office Phone Number: (_____) _____
5. Volunteer Faculty (If any)
Yes ____ No ____ UK ____ UL ____ Other _____
6. Administrative Title: (If any) _____
7. My primary care specialty is:
1) ____ family practice
2) ____ general pediatrics
3) ____ general internal medicine
4) ____ general obstetrics
5) ____ other (please explain) _____
8. I have an earned a) master's in _____
b) doctorate (other than the MD degree) in: _____
9. Short description of current position or practice
(ie, responsibilities and work emphasis): _____
10. The percents of time devoted to the various aspects of my work are as follows:
1) ____ Research
2) ____ Teaching
3) ____ Clinical Care
4) ____ Administrative
5) ____ Service
6) ____ Other (please describe) _____
100% Total _____
7) ____ I have been a primary care practitioner for ____ years.
8) Currently I plan to:
____ continue my current practice.
____ switch to a non-primary care field within the next 12 months.
____ retire from full time practice within the next 12 months.
11. Did you enter primary care directly from residency/fellowship?
1) ____ Yes 2) ____ No
12. I decided on a career in primary care (check the response that most closely reflects your situation):
1) ____ before entering medical school
2) ____ during the first two years of medical education
3) ____ during the last two years of medical education
4) ____ during residency years
5) ____ during fellowship years
6) ____ subsequent to residency and fellowship years
7) ____ Other (please describe) _____
13. Critical experiences influencing me toward a career in primary care included: (Rate as follows: "0" not a factor, "1" a minor factor, "2" an important factor, "3" a major factor, "4" a critical factor)
1) ____ a close relationship with a primary care mentor
2) ____ ambulatory care experience as a student
3) Positive interaction with members of the:
a) ____ department of family practice
b) ____ division of general pediatrics
c) ____ division of general internal medicine
d) ____ department of general obstetrics
4) Clerkships in:
a) ____ department of family practice
b) ____ division of general pediatrics
c) ____ division of general internal medicine
d) ____ department of general obstetrics
5) ____ AHEC selectives
6) ____ electives in primary care
7) ____ relationships with primary care/private practitioners
8) ____ influence of family
9) ____ attractiveness of servicing a community of needy people
10) ____ a desire to work closely with people
11) ____ direct patient contact
12) ____ a chance to practice comprehensive care
13) ____ time for family and non-medically related activities
14) ____ a practice in which I could provide a wide range of medical services
15) ____ a practice in which I could provide care for an entire family
16) ____ manage my own practice (ie, not be "institutionalized")
17) ____ other (please describe) _____
14. Population of community in which I spent my formative years:
1) ____ large city (population 500,000 or more)
2) ____ suburb of a large city
3) ____ medium size city (population 200,000 – 500,000)
4) ____ suburb of a medium size city
5) ____ city of moderate size (population 50,000 to 200,000)
6) ____ suburb of moderate city size
7) ____ small city (population 10,000 to 50,000 – other than suburb)
8) ____ town (population 2,500 to 10,000 – other than suburb)
9) ____ small town (population less than 2,500)
15. Population of community in which I currently live and practice:
1) ____ large city (population 500,000 or more)
2) ____ suburb of a large city
3) ____ medium size city (population 200,000 – 500,000)
4) ____ suburb of a medium size city
5) ____ city of moderate size (population 50,000 – 200,000)
6) ____ suburb of moderate city size
7) ____ small city (population 10,000 to 50,000 – other than suburb)
8) ____ town (population 2,500 to 10,000 – other than suburb)
9) ____ small town (population less than 2,500)
16. I am board certified in my specialty:
1) ____ Yes 2) ____ No
17. I selected my current specialty based on: (Please rate as follows: "0" not important, "1" somewhat important, "2" moderately important, "3" very important, "4" critically important)
1) ____ content of specialty
2) ____ length, mode, and stress of specialty training
3) ____ anticipated salary
4) ____ threat of malpractice suits

Developing Generalists for Kentucky

- 5) _____ mentor role modeling
- 6) _____ time for leisure activities
- 7) _____ time for family activities
- 8) _____ opportunity for direct patient contact
- 9) _____ presumed specialty prestige
- 10) _____ control of hours worked
- 11) _____ intellectual stimulation
- 12) _____ opportunity for participation in long term research program

18. If I had it to do all over again, I would:

- 1) _____ change specialties.
If so, to what? _____
- 2) _____ not enter a primary care field.
If so, I would rather have: _____
- 3) _____ not enter medicine in the first place.
- 4) _____ I would again choose my present primary care specialty.

19. Individual(s) who influenced me to enter primary care either at UKCM or elsewhere (please identify): _____

20. Please describe whether UKCM influenced your decision to enter primary care and whether positive or negative, in what ways. _____

21. Overall, please indicate your level of satisfaction with your career by circling the appropriate number.

| | | | | | | |
|--------------|--------------|----|---|-----------|---|-----------|
| -3 | -2 | -1 | 0 | 1 | 2 | 3 |
| Very | | | | | | Very |
| Dissatisfied | Somewhat | | | Somewhat | | Satisfied |
| | Dissatisfied | | | Satisfied | | |

Thanks very much for responding to this survey. As noted in the cover letter, please call Dr Jarecky at (606) 233-6446 should you prefer to talk rather than write.

Question 13. Critical experiences influencing me toward a career in primary care included: (Rate as follows: "0" not a factor, "1" a minor factor, "2" an important factor, "3" a major factor, "4" a critical factor)

| Items Specialty | 1 Relationship with Mentor | 2 Ambulatory care student experience | 3a Interaction: FP | 3b Interaction: Peds | 3c Interaction: IM | 3d Interaction: OB | 4a Clerkship: FP | 4b Clerkship: Peds | 4c Clerkship: IM | 4d Clerkship: OB |
|---------------------------------|-------------------------------------|-----------------------------------------------|----------------------------|----------------------------|--------------------------|---------------------------------|--------------------------|------------------------------|---------------------------|---------------------------------|
| Family Practice | N = 115 X = 1.46 | 1.57 | 1.13 | 1.02 | .71 | .76 | 1.47 | .97 | .93 | .73 |
| General Pediatrics | N = 50 X = 1.5 | 1.93 | 1.7 | 2.6 | 2.83 | 2.1 | .1 | 2.75 | .38 | .32 |
| General Internal Medicine | N = 31 X = 1.36 | .84 | .23 | .32 | 1.71 | .19 | .32 | .32 | 2.19 | .26 |
| Items Specialty | 5 AHEC | 6 P.C. Electives | 7 P.C. Relationships | 8 Family Influence | 9 Service Needy | 10 Work closely people | 11 Patient Contact | 12 Practice Camp. Care | 13 Have Family Time | 14 Wide Range Services |
| Family Practice | N = 115 X = 1.46 | 1.55 | 2.1 | 1.50 | 2.21 | 2.84 | 2.9 | 2.9 | 1.66 | 2.9 |
| General Pediatrics | N = 50 X = 1.73 | 1.35 | 1.5 | .93 | 1.7 | 2.4 | 2.83 | 2.1 | 1.3 | 1.6 |
| General Internal Medicine | N = 31 X = 1.36 | 1.35 | 1.7 | .94 | 1.84 | 3.03 | 2.87 | 2.97 | 1.4 | 2.45 |
| Items Specialty | 15 Care Entire Family | 16 Manage Own Practice | | | | | | | | |
| Family Practice | N = 115 X = 2.6 | 2.36 | | | | | | | | |
| General Pediatrics | N = 50 X = .27 | 1.55 | | | | | | | | |
| General Internal Medicine | N = 31 X = .65 | 1.41 | | | | | | | | |

of a generalist specialty by all respondents, 75% of the respondents indicated that the opportunity for direct patient contact was an important to critical factor; 67% mentioned the chance to practice comprehensive care; 65% mentioned a desire to work closely with people; and 61% mentioned a practice in which one could provide a wide range of medical services.

Each of the respondents was asked to rate 22 items (concerned with either educational experiences or community and practice characteristics) in terms of how critical each item was in influencing the choice of a generalist career (0 = not a factor, 4 = a critical factor). A three-way analysis of variance with one repeated measure was carried out to compare the responses of the three generalist specialties, practice location (rural vs urban), and differences in item importance (repeated measure). The analysis indicated that the three groups rated the items at different levels ($p = 0.024$) and that there was not a significant difference between rural and urban physicians ($p = 0.327$). The items differed significantly in how critical they were in influencing specialty choice ($p < 0.001$). The interaction between specialty and practice location was not significant ($p = 0.428$). The interactions between item importance and specialty ($p < 0.001$) and item importance and location of practice ($p < 0.001$) were statistically significant. The three-way interaction was not significant ($p = 0.776$). Because of this complex pattern of results and inspection of the means, analyses of simple effects were carried out to compare item importance for each specialty. All three of the analyses of simple effects were significant ($p < 0.001$) for each group.

Table 1 presents the most critical items for each of the three specialties as identified by Fisher's PLSD post hoc test. For both internists and pediatricians, clerkships in their respective specialties were importance experiences in the decision to enter the generalist career. In addition, the pediatricians ranked as important their ambulatory care experiences in fourth-year elective courses. Interestingly, the family practitioners did not rate the clerkship in the department of family practice as an important factor in their career selection. Practitioners in all three specialties indicated that important critical experiences in the selection of a generalist career were direct patient contact, a chance to practice comprehensive care, and a desire to work closely with people.

Across the three generalist specialties, the selection of current specialty was based on simi-

Question 17. I selected my current specialty based on: (Please rate as follows: "0" not important, "1" somewhat important, "2" moderately important, "3" very important, "4" critically important)

| Items Specialty | 1 Specialty Content | 2 Length, Made, Stress Training | 3 Solory | 4 Molpractice Threot | 5 Mentor Role Madel | 6 Leisure Time |
|---------------------------------|---------------------------|---------------------------------------------|----------------------------|------------------------------|---------------------------------|----------------------|
| Family Practice | N = 106 X = 3.0 | 1.7 | .81 | .67 | 1.74 | 1.4 |
| General Pediatrics | N = 38 X = 3.1 | 1.37 | .55 | .37 | 1.87 | 1.03 |
| General Internal Medicine | N = 30 X = 3.1 | 1.57 | .73 | .47 | 1.9 | 1.3 |
| Items Specialty | 7 Family Time | 8 Patient Cantact | 9 Specialty Prestige | 10 Control of Hours | 11 Intellect. Stimulation | 12 Do Research |
| Family Practice | N = 106 X = 1.6 | 3.3 | .79 | 1.6 | 2.3 | .11 |
| General Pediatrics | N = 38 X = 1.26 | 3.10 | .58 | .87 | 2.3 | .08 |
| General Internal Medicine | N = 30 X = 1.27 | 3.2 | .97 | 1.4 | 3.2 | .3 |

Table 1. Items Most Critical to the Choice of a Generalist Career by Groups of Respondents

| | |
|-------------------------------------------------------------------------|-------|
| Family Practice | |
| Attractiveness of serving a community of needy people | 2.212 |
| Manage my own practice (ie, not be "institutionalized") | 2.336 |
| A practice in which I could provide care for an entire family | 2.611 |
| A desire to work closely with people | 2.841 |
| Direct patient contact | 2.920 |
| A practice in which I could provide a wide range of medical services | 2.947 |
| A chance to practice comprehensive care | 2.965 |
| Pediatrics | |
| Ambulatory care experience as a student | 1.950 |
| A chance to practice comprehensive care | 2.100 |
| A desire to work closely with people | 2.400 |
| Positive interaction with members of the division of general pediatrics | 2.675 |
| Clerkships in division of general pediatrics | 2.750 |
| Direct patient contact | 2.825 |
| Internal Medicine | |
| Clerkships in division of general internal medicine | 2.194 |
| A practice in which I could provide a wide range of medical services | 2.452 |
| Direct patient contact | 2.871 |
| A chance to practice comprehensive care | 2.968 |
| A desire to work closely with people | 3.032 |

Additional Data

The following presents data not already discussed in the manuscript:

Question 10 "The percents of time devoted to the various aspects of my work"

This question addresses the percents of time devoted to various aspects of work. All three specialties reported spending the majority of their time in Clinical Care (86.3%). This was followed by administrative (4.7%), teaching (4.3%), service (3.4%) and finally, research (.7%). The difference between these areas is significant ($df = 4,736$ $F = 963.455$ $P < .001$). There was not a significant difference between the three specialties and how they spend their time ($df = 184,740$ $F = .007$ $P = .99$).

Question 11 "Did you enter primary care directly from residency/fellowship?"

93% of respondents entered from a residency or fellowship.

Question 12 "I decided on a career in primary care"

This question addresses when the decision to pursue a career in primary care was decided. There was not a significant difference between specialties and when the decision to pursue primary care was made ($df = 2,21$, $F = .818$, $p = .45$). 43% made the decision before entering medical school, 4% made the decision during the first two years of medical education, 38% during the last two years of medical school, 13% during residency years, 0% during fellowship years, 1% subsequent to residency and fellowship years and 1% other.

Question 13 "Critical experiences influencing me toward a career in primary care included:"

This question addresses critical experiences that were influential in the decision to make a career in primary care. Between the specialties, there was a significant difference between influential items ($df = 42$, 3843 $F = 14.743$, $p = .001$). Table "Question 13" presents the means from each specialty for each question item. The manuscript text further discusses results from this question.

Question 14 "Population of community in which I spent my formative years"

This question addresses the size of the community in which the respondent spent formative years. Below represents the frequency per each item. In the manuscript, the data were recorded and results discussed.

| | |
|---------------------------------------------|-------|
| Large city (population 500,000 or more) | 10% |
| Suburb of a large city | 8.5% |
| Medium size city (pop. 200,000-500,000) | 6.5% |
| Suburb of a medium size city | .01% |
| City of moderate size (pop. 50,000-200,000) | 8.5% |
| Suburb of moderate city size | 2.5% |
| Small city (population 10,000-50,000) | 16.6% |
| Town (population 2,500-10,000) | 23.7% |
| Small town (population less than 2,500) | 22.7% |

Question 15 "Population of community in which I currently live and practice"

This question addresses the size of the community in which the respondent currently lives and practices. Below represents the frequency per each item. In the manuscript, the data were recorded and results discussed.

| | |
|---------------------------------------------|-------|
| Large city (population 500,000 or more) | 5.5% |
| Suburb of a large city | 3.5% |
| Medium size city (pop. 200,000-500,000) | 22.8% |
| Suburb of a medium size city | 2.5% |
| City of moderate size (pop. 50,000-200,000) | 5.5% |
| Suburb of moderate city size | 1.5% |
| Small city (population 10,000-50,000) | 22.8% |
| Town (population 2,500-10,000) | 29.4% |
| Small town (population less than 2,500) | 6.1% |

Question 17 "I selected my current specialty based on"

This question addresses the importance of factors influential in the selection of the specialty as well as specialty characteristics. Between the specialties, there was a significant difference between influential items ($df = 22$, 1881 , $F = 2.085$, $p = .002$). Table "Question 17" presents the means from each specialty for each question item. The manuscript text further discusses results from this question.

Question 18 "If I had to do it all over again, I would"

This question addresses if the respondent would remain in his or her present primary care specialty. The following presents the frequency responses for each item.

| | |
|---------------------------------------------------------|-----|
| Change specialties: | 12% |
| Not enter a primary care field | 5% |
| Not enter medicine in the first place: | 6% |
| I would again choose my present primary care specialty: | 66% |

Question 21 "Overall, please indicate your level of satisfaction with your career"

This question addresses the extent to which respondents are satisfied with their careers. Family practitioners rated their level of satisfaction at a mean of 1.8, indicating a level of "somewhat satisfied." General pediatricians rated their level of satisfaction at a mean of 2.1, indicating a level of "somewhat satisfied." The general internists rated their level of satisfaction at 1.5, indicating a level of "somewhat satisfied." Analysis of variance indicated no significant difference between the specialties and their level of satisfaction ($df = 2,181$, $F = 1.45$, $p = .0236$).

lar lifestyle items. All three types of physicians rated the opportunity for direct patient contact, the content of the specialty, and intellectual stimulation as the most important lifestyle factors in their specialty selection. In addition, for general internists and general pediatricians, mentor role modeling was a most important selection factor. Practitioners in all three specialty groups ranked time for family activities, time for leisure activities, control of hours worked, and length, mode, and stress of specialty training as important factors. The least important items for all three specialties were opportunities for participation in long-term research programs, salary, prestige, and the threat of malpractice.

Discussion

Our findings indicate that educational experiences are meaningful influences on students interested in a generalist career and that they have some influence on the particular specialty chosen. A particular specialty under consideration as a career choice may be viewed as a more attractive specialty after an educational experience in that field. The results of our study also indicate that formal ambulatory care training experiences are not critical for the selection of a generalist career, but that they could certainly heighten, if not confirm, interest in a generalist specialty.

Our study has several limitations. First, our data draw on respondents' introspection about the factors influencing their career decisions. As discussed by Pathman and Agnew,¹⁰ several biases are inherent in this attribution process. Our study, while relying on respondents' introspection, also examines career selection in light of a controlled association: the absence of a required ambulatory care training experience in the curriculum for the cohort sampled. Another limitation is that the sample is drawn from only one institution; therefore, its results may not be generalizable to other institutions and their graduates.

Two findings of the study are significant for health care planners and educators. First, many students from rural areas elect to practice medicine in rural communities. Efforts that encourage students from rural communities to enter medical school appear to produce the rural physicians that the efforts intend to create. Second, many students "choose" to enter a generalist career before entering medical school. Given UKCOM's

mission to produce generalists, student-expressed interest in a generalist career is noted during the interview process, but it is not used as an admission criterion. As other investigators have suggested,^{11,12} institutions that want to increase the number of generalists could implement admission policies that include interest in a generalist career in the admission criteria and could design curricular experiences that include exposure to general medicine and to role models to reinforce and heighten the students' interest. Under the aegis of the Robert Wood Johnson Foundation, UKCOM has implemented required ambulatory care experiences in the third year that incorporate family practice, internal medicine, and pediatrics. As graduates of the new curriculum enter residency programs and medical practices, it will be imperative to follow their career choices and to assess the influence of the new curriculum on these choices.

References

1. Babbott D, Baldwin DC Jr, Killian CD, Weaver SO. Trends in evolution of specialty choice. Comparison of US medical school graduates in 1983 and 1987. *JAMA*. 1989;261:2367-2373.
2. Weil PA, Schleiter MK. National Study of Internal Medicine Manpower: VI. Factors predicting preferences of residents for careers in primary care or subspecialty care and clinical practice or academic medicine. *Ann Intern Med*. 1981;94:691-703.
3. Lieu TA, Schroeder SA, Altman DF. Specialty choices at one medical school: recent trends and analysis of predictive factors. *Acad Med*. 1989;64:622-629.
4. Osborn EH. Factors influencing students' choices of primary care or other specialties. *Acad Med*. 1993;68:572-574.
5. Jarecky RK, Schwartz RW, Haley JV, Donnelly MB. Stability of medical specialty selection at the University of Kentucky. *Acad Med*. 1991;66:756-761.
6. Jarecky RK, Donnelly MB, Rubeck RF, Schwartz RW. Changes in the patterns of specialties selected by high and low academic performers before and after 1980. *Acad Med*. 1993;68:158-160.
7. Kassler WJ, Wartman SA, Silliman RA. Why medical students choose primary care careers. *Acad Med*. 1991;66:41-43.
8. 1991-92 AAMC Curriculum Directory. Washington, DC: American Association of Medical Colleges, 1991.
9. "Medical Schools," *US News and World Report*. 1995;118(March 20 '95):98-99.
10. Pathman DE, Agnew CR. Querying physicians' beliefs in career choice studies: the limitations of introspective causal reports. *Fam Med*. 1993;25:203-207.
11. Martini CJ, Veloski JJ, Barzansky B, Xu G, Fields SK. Medical school and student characteristics that influence choosing a generalist career. *JAMA*. 1994;272:661-668.
12. Burke W, Baron RB, Lemon M, Losh D, Novack A. Training generalist physicians: structural elements of the curriculum. *J Gen Intern Med*. 1994;9(4 Suppl 1):S23-30.

Geographic Origin and Its Impact on Practice Location in Kentucky

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This study examined which medical students from the University of Kentucky College of Medicine are most likely to return to their geographic origins to practice medicine and the frequency with which this occurs. This study is based on statistical analysis of longitudinal data (1974-1985). The database includes 1243 matriculants for whom residency data were available. Follow-up data were available for 1093 physicians-in-practice. Results indicate that a significant percentage of matriculants return to their in-state district of origin to practice. Significant predictors of practice location included gender, undergraduate institution, and residence at admission. However, these factors explained only 8% of the variance in physician practice location. Expanding the model to include location of residency program and specialty choice contributed an additional 14% of the variance. Admissions officers seeking to improve the ratio of graduates practicing in rural areas should devise new measures to assess applicant's attraction to positive aspects of rural medical practice or small town life.

The affinity model suggests that physicians choose practice locations because they find them desirable in light of their previous interests or backgrounds.³ The affinity model would predict that matriculants to medical schools are likely to locate their medical practices based on their geographic origins.⁷ Previous research on physician supply in rural areas has established the applicability of the affinity model in validating assumptions that students with rural ties are more likely to practice in rural areas.^{1,8,11} Using national data from the Association of American Medical Colleges (AAMC), Kassebaum and Szenas⁵ compared the practice plans of medical students with and without rural ties from 1982-1992. They found that rural students were more likely to report in separate questionnaires completed before medical school and upon graduation that they

planned to practice primary care in a rural area. However, the authors conclude that only 5% of students "contemplate rural practice after graduation" and therefore recruitment of these students can make only a limited contribution to the shortage of physicians in rural areas. Using national American Medical Association Physician Masterfile data, Rosenblatt et al¹⁰ found that 12.5% of physicians graduating between 1976 and 1985 were practicing in rural areas in 1991. The authors of this study report that production of rural physicians varied by medical schools according to their location, ownership, production of family physicians, and funding. Rosenblatt et al found the strongest association between percentage of students choosing rural practice and the rurality of the state in which the medical school is located. They noted that twelve schools accounted for over 25% of the physicians entering rural practice from this cohort. In the 12 schools, production of rural physicians ranged from 18% to 41%. Although Rosenblatt et al did connect production of rural physicians to attending medical school in a predominantly rural state, the extent to which students in the study had rural origins was not examined.

Admission officers charged with the selection of students who are most likely to choose to practice in rural and other underserved areas within their states rely upon the affinity model.^{2,9} In selecting candidates for admission, demographic characteristics (age and gender) and cognitive characteristics such as scores on the Medical College Admissions Test (MCAT) and undergraduate grade point averages (GPAs) also contribute to admission decisions.⁶ Building upon findings from the previously cited research, this study is designed to provide further insight into the relationship between matriculant antecedents, specialty selection, and practice location of graduates of the University of Kentucky College of Medicine. To that end, the first purpose of this

study is to examine longitudinally a cohort of matriculants to determine the extent to which they display geographic affinity in their subsequent choice of practice location. The second purpose of this study is to predict which students are most likely to return to their geographic origins to practice medicine.

Method

The study was conducted at the University of Kentucky College of Medicine. During the study period, requirements established by the state's Council on Higher Education dictated that 90% of matriculants should be in-state applicants. Students admitted from 1974 through 1985 served as the study population so that data would be available on their practice locations subsequent to the completion of their residency programs. Data were gathered from three sources. Matriculants' class year, age, gender, county of residence, undergraduate institution attended, cumulative undergraduate grade point averages, and MCAT scores were available from class characteristics on file in the admissions office. Because the MCAT test forms were changed during the study period (1977), subscale scores were standardized using national means and standard deviations and averaged for a composite MCAT score. These composites were interpreted as Z scores with an expected mean of zero and standard deviation of one. Matriculants' undergraduate institutions were categorized as the University of Kentucky, other Kentucky public universities, Kentucky private colleges and universities, and out-of-state colleges and universities.

As a second source of data, graduates' specialty choices and locations of residencies were available from the student affairs office. There were 70 specialty categories. Graduates entering internal medicine, pediatrics, and family practice were coded as entering primary care specialties; all others were coded as non-primary care specialties. The third source of data relevant to physicians' practice specialties and locations were available via the institution's alumni office. Physicians' specialties were coded in the same fashion as graduates. Physicians practicing internal medicine, pediatrics, or family medicine were designated as entering primary care specialties. Physicians practicing subspecialties of internal medicine and pediatrics were coded as entering non-primary care specialties.

County of matriculants' residence at the time

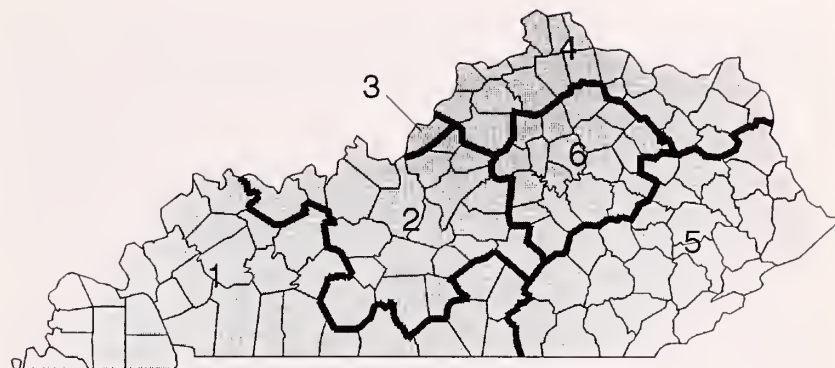


Fig 1

of medical school application and their subsequent practice locations were coded according to Kentucky's six Congressional districts. Once coded, matriculants' county of residence was called "district of origin" and physicians' practice location was called "practice district." Although each of the Commonwealth's Congressional districts are of roughly the same population, the nature of the districts varies by population density, square miles, topographical features, social and economic features, and proximity to major metropolitan areas. Characteristics of the districts depicted in Fig 1 are as follows: District 1 in the far western part of the state and District 2 in the southwest are agrarian. District 5 is in the Appalachian southeast. These three districts are primarily rural. District 3, Kentucky's largest metropolitan area, and District 4 in the north and northeast part of the state are largely industrial and urban centers. District 6, in central Kentucky, is the home of the study institution and serves as a technological and service base for several other districts.

Results

Over the study period (1974-1985), 1250 students matriculated at the University of Kentucky College of Medicine. Geographic data on site of residency training were available for 1243 graduates and practice locations were available for 1093 physicians-in-practice. The mean age of the study population at matriculation was 23.3 (standard deviation = 2.97) and 72.1% were male. Thirty four percent completed their undergraduate degrees at the University of Kentucky, 22% at Kentucky public universities, 15% at Kentucky private

Practice Location in Kentucky

Table 1. Relationship of District of Origin to Practice Location by Percentage

| | Pre-admission District of Origin | Practice Locations | | In-state Returnees** to District of Origin |
|---------------------------|----------------------------------------|--------------------|--------------|--------------------------------------------------|
| | | Kentucky* | Out-of-state | |
| Out-of-state | 7.96 | 13.2 | 86.8 | — |
| District 1 (Agrarian) | 12.0 | 56.9 | 44.1 | 41.5 |
| District 2 (Agrarian) | 10.3 | 43.3 | 56.7 | 47.7 |
| District 3 (Metropolitan) | 15.0 | 44.0 | 56.0 | 48.5 |
| District 4 (Industrial) | 16.4 | 59.1 | 40.9 | 52.2 |
| District 5 (Appalachian) | 12.5 | 61.0 | 39.0 | 43.1 |
| District 6 (Service) | 33.7 | 46.1 | 53.9 | 68.9 |

* Percentage of total graduates locating their practice in Kentucky.

** Percentages of Kentucky returnees to district of origin are based on percentage of total graduates practicing in Kentucky and excludes those practicing out-of-state.

colleges or universities, and 29% at out-of-state colleges or universities. Over the study period, 92% of the matriculants were Kentucky residents. The mean cumulative undergraduate GPA was 3.54. The mean composite MCAT score (based on subscale scores standardized on the national means and standard deviations on each year) was .32 (standard deviation = .60). Of the study graduates, 51% entered primary care residency programs and 31% remained in Kentucky for their

residency training. Of the physicians-in-practice for whom there were data (1093), 42% were in primary care practices. Table 1 presents the breakdown of preadmission districts of origin by subsequent practice locations.

To examine the first study question, chi-square analyses were performed to address whether physicians' practice districts matched their districts of origin. The statistical analyses focus on physicians practicing in Kentucky. Of those practicing in-state, chi square analyses reveal that physicians were most likely to practice in their district of origin (χ^2 (25, $n = 485$) = 466.8, $p < .0001$), rather than in other districts in Kentucky. Other physicians who stayed in-state, but did not return to their district of origin, tended to locate their practices in the district containing the study institution.

To address the second purpose of this study, we performed regression analyses to predict practice location. Predictors included age, gender, undergraduate institution attended, cumulative undergraduate GPA, composite MCAT scores, district of origin, residency program site, and residency and practice specialties. Although both cumulative undergraduate GPA and MCAT scores as well as residency and practice specialties are strongly associated with each other, we retained all variables in the model. In order to define more clearly the relationship between these factors and practice location, we assigned matriculants' choices of practice locations a score based on a 6-point scale. The scale reflected the health care delivery priorities of both the institution and the Commonwealth which focus on educating Kentucky residents and addressing Kentucky's health care needs. The scale values are presented in priority order with the percentage of physicians-in-practice in each: (1) Kentucky rural, 19%; (2) Kentucky urban, 29%; (3) adjoining Appalachian state, 15% (West Virginia, Tennessee, Virginia); (4) adjacent Southeastern state, 9% (Mississippi, Alabama, Georgia, South Carolina, North Carolina); (5) adjoining Midwestern state, 11% (Ohio, Indiana, Illinois, Missouri); (6) non-adjoining other states, 17%. The scale values constituted our dependent variable for the regression model.

As shown in Table 2, the model revealed several significant predictors. Given an intercept of 4.25, the significant negative beta coefficient for gender indicates male matriculants are more likely to locate their practices in Kentucky's rural or urban areas. Similarly the negative beta weight for in-state public schools indicates matriculants

Table 2. Multiple Regression Analysis of Predictors of Matriculants Practice Location¹

| Variable | Beta Coefficient | F Ratio | p value |
|-----------------------------------------------------------------------|------------------|---------|---------|
| Preadmission demographic academic factors (8% of the variance) | | | |
| Age | .017 | .84 | ns |
| Male Gender | -.550 | 21.31 | .0001 |
| Undergraduate Institution | | | |
| In-state Private | -.063 | | |
| In-state Public | -.251 | | |
| Out-of-State | .661 | 13.48 | .0001 |
| (Study Institution) | | | |
| Cumulative Undergraduate GPA | .055 | .09 | ns |
| Standardized Composite MCAT | .111 | 1.53 | ns |
| County of Residence on Admission | | | |
| Rural | -1.124 | | |
| Urban | -.816 | 15.50 | .0001 |
| (Out-of-State) | | | |
| Residency factors (14% of the variance) | | | |
| In-State Residency Program | -1.113 | 113.96 | .0001 |
| Primary Care Residency Specialty | -.320 | 10.65 | .0011 |

Total variance accounted for by the model = 22%

¹ Practice location categories: 1 = Kentucky rural; 2 = Kentucky urban; 3 = adjoining Appalachian state; 4 = adjacent Southeastern state; 5 = adjoining Midwestern state; 6 = non-adjoining out-of-state.

attending undergraduate institutions in-state are more likely to stay in Kentucky to practice medicine. Matriculants attending out-of-state undergraduate institutions were more likely to locate their practices out-of-state. The negative beta coefficients for county of residence indicate matriculants from especially rural but also urban counties tend to locate their practices in Kentucky. Similarly, graduates choosing residency programs located in-state tend to stay in-state to practice. Finally, choice of a primary care residency program is predictive of staying in Kentucky to set up medical practice. Review of the regression model indicates the six preadmission demographic and academic factors accounted for 8% of the variance in practice location score. In-state site of residency and primary care specialty selection accounted for 14% of the variance. The final model was significant ($F(11, 1024) = 26.58, p < .0001$) and accounted for 22% of the variance in practice location score.

Discussion

Our study provides empirical support for the affinity model. Review of the study findings indicated that 92% of University of Kentucky College of Medicine matriculants were Kentucky residents; 48% of our graduates chose to remain in Kentucky to practice medicine. Looking more closely, we found that a significant number of in-state matriculants established practice locations within their districts of origin. Those Kentucky resident matriculants not returning to their district of origin frequently chose to practice in District 6, where they had attended medical school. Overall, matriculants who were male, had attended in-state schools as undergraduates, had completed in-state residencies and were practicing a primary care specialty were more likely to locate their practices in Kentucky. Of those graduates choosing to practice medicine outside of Kentucky, the majority located their practices in states directly adjoining the Commonwealth. Combining graduates practicing in Kentucky with those practicing in adjacent or adjoining states, it is noteworthy that only 17% of graduates chose to practice medicine outside of the region, suggesting a strong regional affinity.

Two additional findings are of interest to those concerned about educating physicians to serve Kentucky. First, indicators of academic achievement (MCAT and GPA) were not predictive of graduates who opted to practice out-

of-state. Therefore, our data do not suggest that our most academically capable students are leaving the state to set up practice elsewhere. Second, we found that a significant proportion of rural physicians were practicing in their district of origin. This indicates that rural health care needs are being addressed in part by persons not just with a general rural affinity but with an even more specific and localized affinity.

It is important to consider these findings in light of previous research. Our findings indicate that 41% to 47% of matriculants from rural districts returned to locate their practices in the same rural district. Using a national data set of physicians graduating from 1976-1985 who were in practice in 1991, Rosenblatt et al¹⁰ reported 12.5% of medical school graduates were practicing in rural areas. We posit that our high percentage of graduates practicing in rural areas is best accounted for by the rural nature of Kentucky. Indeed, Rosenblatt and colleagues concluded that an important mediating factor in the choice of practice location was attending medical school in a predominantly rural state. However, it is not clear as to whether physicians practicing in rural areas choose to do so because of a rural or district affinity or rather a more general state affinity which only provides a limited non-rural experience for its citizens. Similarly, the relatively low percentage of graduates who opt to practice outside of the region may be an indicator of an insular life experience and world view of Kentucky students.

There are several limitations to the findings in this study that should be noted. First, this study examines a cohort from one institution and therefore may not be generalizable to all schools. However, the study cohort does span 11 years of medical school graduates which makes for a large data set. Second, some of the findings in this study may be influenced by the priorities of medical school admission committees during a particular historical period. For example, the higher than average MCAT scores among this cohort potentially reflect an emphasis on cognitive factors for admission during this study period. Many institutions, including the one in which the current study is based, are increasing their emphasis on rural background and potential specialty choice as criteria for admission. Another limitation in drawing conclusions about practice locations stems from the nature of the state within which the study was conducted. The institution in this study clearly fits into Rosenblatt et al's¹⁰ model

Practice Location in Kentucky

of one that is likely to produce more rural physicians.

Review of the regression analyses indicates that commonly used preadmission factors related to age, gender, undergraduate institution attended, cumulative undergraduate GPA, MCAT score, and county of residence at matriculation explained only 8% of the variance in physician practice location. Expanding the model to include location of residency program and specialty choice contributed an additional 14% of the variance. However, it is important to note that the majority of the variance in the predictive model was not explained. Therefore, it is doubtful that increasing the number of males accepted or increasing the number of admissions extended to students from particular counties or who have attended particular colleges and universities will dramatically impact the number of graduates staying in Kentucky and entering rural practice.

Combinations of professional, personal, sociocultural, and economic factors are well recognized as influencing physician's practice location decisions.⁴ Admission officers and residency directors seeking to improve the ratio of graduates practicing in their home states should endeavor to devise new measures to assess the affinity for district of origin of our physicians-in-training. Measures which assess an applicant's attraction to positive aspects of rural medical practice or small

town life may help determine those individuals most likely to opt to practice in rural areas.

References

1. Bruce TA. How do we prepare providers: Physicians. *J Rural Health*. 1985;1:18-21.
2. Colwill J. Where have all the primary care applicants gone? *N Engl J Med*. 1992;326:387-393.
3. Crandell LA, Dwyer JW, Duncan RP. Recruitment & retention of rural physicians: Issues for the 1990s. *J Rural Health*. 1990;6(1):19-38.
4. Cutchin MP, Norton JC, Quan MM, Bolt D, Hughes S, Lindeman B. To stay or not to stay: Issues in rural primary care physician retention in eastern Kentucky. *J Rural Health*. 1994;10:273-278.
5. Kassebaum DG, Szenas PL. Rural sources of medical students, and graduates' choice of rural practice. *Acad Med*. 1993;68:232-236.
6. Mitchell KJ. Traditional predictors of performance in medical school. *Acad Med*. 1990;65:149-158.
7. Nowacek G, Sachs L. Demographic variables in medical school admission. *Acad Med*. 1990;65:140-144.
8. Rabinowitz HK. Estimating the percentage of primary care rural physicians produced by regular and special admissions policies. *J Med Educ*. 1986;61:598-600.
9. Rabinowitz HK. Evaluation of a selective medical school admissions policy to increase the number of family physicians in rural and underserved areas. *N Engl J Med*. 1988;319:480-486.
10. Rosenblatt RA, Whitcomb ME, Cullen TJ, Lishner DM, Hart LG. Which medical schools produce rural physicians? *JAMA*. 1992;268:1559-1565.
11. Vanselow NA. Medical education and the rural health crisis: A personal perspective from experiences with five states. *Acad Med*. 1990;65:Supplement, S27-S31.



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William H. Mitchell, MD

KMA President 1996-97

Unification, consensus, advocacy,
compromise, communication. . .

. . . the conversation of this highly accomplished surgeon is peppered with bridge-building words as he, William H. Mitchell, MD, assumes the mantle of leadership of the Kentucky Medical Association. And make no mistake about it, this bridge building must have quality care and patient advocacy as its basis and foundation.

After spending any length of time with KMA's new president, it becomes evident that he is a man with a strong sense of responsibility for his colleagues — rural and urban, surgical and primary care, solo and group practitioners — and for his patients. He is a man who sees the big picture and who speaks eloquently about his perspective of the role he is undertaking.

"To represent the mood and disposition of the membership, to hear and be clear about the voice of the House of Delegates, to hear the voice of the Board of Trustees, and to continue to implement the policies established by the organization is to me the primary role of the KMA President. At the same time, it is the role of the President to anticipate change and try to help develop policies to cope with those changes so that the organization and the unification of the membership has its best and most positive impact in helping us generate an environment for physicians to continue to render *good quality patient care*."

He continues, "My main leadership goal is to leave the

organization as unified as it is now, and hopefully even more unified to face the changes yet to come. The 'come on guys, this way, follow me' leadership is not my style. My experience indicates that people who are good leaders, even great leaders, do not lead that way. There are people who at a point in time are capable of changing or modifying a direction from what might not be a good goal toward a goal that is even more pertinent."

Dr Mitchell is particularly cognizant that there is no closer, more honored bond than the one that exists between physicians and their patients. His comments are pragmatic. "Our number one priority is always the patient," he affirms. "There will always be potential divisions conspiring to divide the house of medicine — that's because the house of medicine is not homogeneous. We're not all the same — surgical, primary care, rural, urban, academic, private practice oriented. But, we do have areas of commonality with which no one can argue, and the most important is our patient/physician relationship and the desire to take care of our patients. That cuts across those divisions.

"The makeup of the House of Delegates and Board of Trustees encompasses all of the diverse groups. But taken as a whole, KMA has the capacity to represent the physicians of the state and that's our main mission — to represent our physicians and

move the organization in a direction to influence the changes that are in our patients' best interest."

A Changing World

Dr Mitchell recognizes that the issue of managed care has never been more acute. With massive changes continuing to pulse through the medical community, representatives of organized medicine need to be diligent in making sure that the rights of physicians are protected.

"To stay unified and organized in an environment that is conspiring to divide the house of medicine in many ways — and I very much think of us as the house of medicine — is also a major priority," he says. "The goal and direction of leadership is to ensure that group power, group influence is being used constructively in representation of the desires of the members of the group. With clear direction and clear purpose, we have a much greater chance of a successful outcome."

Knowing that unrelenting change is one condition physicians can always count on, and that they must constantly hone their capacity to keep pace with it, Dr Mitchell advocates seeking opportunities in that change. He has a history of taking charge and speaking up for issues in which he believes. He always sees positives for physicians, even when challenged by exterior forces.

"Being a doctor is one of the best ways to spend your life. I can't imagine doing anything other than something medically related. So I focus on the positives and the category of opportunities that always occur in a changing environment. One might in one way look at managed care as a technology — a change in procedure. Just as we have coped, by virtue of our efforts, with technological and pharmacological changes in the past, we need to cope with the technological changes of managed care. We need to be in a position to assess the impact managed care contracts and contractual arrangements will have on individual physicians. To negotiate a contract through a group situation rather than an individual situation presents a far more advantageous position. Now, that doesn't diminish my respect for individual private practice. My perspective on the benefits and limitations of individual practice comes through experience — I'm a private solo practitioner with no affiliation with any group.

"Third party payors are seeking managed care contracts with large groups of physicians. In my opinion, the Kentucky Medical Association should direct its efforts to help physicians in Kentucky develop a statewide network of physicians so that both group practice and private practice physicians can come into one network, one physician empowered organization that can assist in providing information to be used in negotiating contracts. In that way, our approach to changing technology is the same as our proposed approach to the changing technology of managed care."

Organized Medicine

The Madison County Medical Society introduced Dr Mitchell to organized medicine when he established his practice in Richmond. It was there that he became aware of

how KMA functions — through the House of Delegates and the Board of Trustees. "My interest was peaked as I saw value in terms of a great many questions and pressures that have always confronted the profession."

He did not seek a leadership role in the Association, but was content to do his best at each point in time. "I sought a way to have input in an organized and effective fashion to effect a reaction to the changes that would be positive. At each level it seemed I was just doing what was needed at the time. I've always felt that I could be and had been an effective voice in the organization. By evolving and moving along in KMA, I've seen those changes and evolutions occur that have made us stronger.

"There have been times when I feel I've spoken for folks who might not have had an organized voice to speak. I felt called to organize the rural caucus. I actually give Emanuel Rader a great deal of the credit for that. He was a KMA Trustee and I remember in the mid 80s when he and I and several other physicians were talking about 'Mannie's mountain caucus.' That seemed like such a 'pie in the sky' idea, but with Emanuel's support and that of other physicians in positions of leadership, we succeeded in organizing the 'rural caucus.' We thought 'mountain' was a little too heavy!

"A caucus itself is not necessarily action oriented. The goal of the rural caucus was to provide rural physicians with a unified voice within the organization, to provide a forum where we could exchange ideas, and to be sure we all understood the issues that were going to be voted on on the floor of the House of Delegates, *before* we got to the floor of the House. It wasn't to say 'we'll go vote as a block,' but everyone could feel secure in voting their own mind because they left our meetings with a full understanding of the issues. That's one of the most helpful things one

can bring to an organization — to ensure that those representing the members understand clearly what they are representing, and to have a forum where all voices can be heard. But once everyone has a say and we vote, then it's majority rule. We set policy. Then it's the obligation of leadership to implement that policy to the best they can."

KMA Membership

If there's one thing that Dr Mitchell has learned through the years, it's that getting involved is the key to the future of organized medicine. It's something Dr Mitchell wants to remind all doctors during his one-year tenure at the top of the KMA.

"Organizations increase membership when they increase the perception on the part of prospective members that there is a need and a benefit of belonging to the organization, of being actively involved in the legislative process — that one individual physician does make a difference. The Kentucky Medical Association provides a forum to hear everyone and all the positions and a mechanism to bring all those positions into a common purpose and a common policy. Historically, KMA membership has increased in times of crisis rather than in time of peace and plenty. During the outside crisis resulting from House Bill 250, the 2% provider tax, our membership actually increased. It surprises me that physicians don't immediately see the benefit and the need. If everyone were a KMA member and everyone participated, we would only have to do 1% of the work we must do right now."

A quick glance at his curriculum vitae attests that Dr Mitchell has set an example by his own involvement over the years. The listings of professional memberships, professional activities, hospital affiliations, academic appointments, and professional appointments seem to go on and on.



Dr William H. Mitchell's family proudly shared in his inauguration as the Kentucky Medical Association's 146th President. Pictured with Dr Mitchell, L to R, are his wife Winnie, youngest son Clay, and his mother. The Mitchell's other two children, son David and daughter Ellen, were unable to attend the inauguration.

This energetic surgeon sums up his dedication to organized medicine by calmly stating, "I was pleased to be president *simultaneously* of the Hiram Polk Surgical Society, the Kentucky Chapter of the American College of Surgeons, and the Madison County Medical Society."

The Legislature

"My greatest insight from the activities in Frankfort was that one person or one group of individuals can influence the legislative process — that it's by activity, awareness, and participation in the process that an influence can be exerted," confirmed Dr Mitchell on his enlightenment through exposure to the 1996 Kentucky General Assembly, the most difficult the Association has undertaken. "I very clearly saw that in the legislative process, doing nothing is a much worse alternative than trying to do something."

He continued enthusiastically, "Armed with the support of our membership and the background of

experienced lobbyists, we approached a legislative session that presented tremendous challenges. What I witnessed was that through an organized, coordinated, albeit strenuous effort, we were able to win major revisions in the onerous HB 250 and accomplished repeal of the provider tax. When was the last time you heard of a tax being repealed? That's remarkable!

"The expertise, commitment, and energy that was expended by our Legislative Quick Action Committee and our lobbyists was as good as it possibly could have been. In my mind if you come out of an effort, no matter the results, and you believe in your heart that you've done the best you could, then that's the benchmark for a successful effort. That's what I would say about KMA's lobbying effort — it was excellent."

Background

Dr Mitchell was born in 1943 in Salisbury, Maryland, the son of native Kentuckians who were both schoolteachers. His mother

began teaching in a one-room schoolhouse in Blue Diamond, Kentucky, and his parents met and married in Richmond, Kentucky. In the late 40s they lived in Wilmington, Delaware, where his father worked as a fireman for the Pennsylvania Railroad. When Dr Mitchell was in first grade his father, who had a bachelor's degree in education from Cumberland College, began teaching science and serving as an athletic coach. Dr Mitchell grew up in Wilmington, attending a public grade school and a Catholic high school, graduating in 1960.

His decision to pursue medicine is one he's never regretted. Even with all the changes in health care, Dr Mitchell says that being a physician "means everything to me. I wanted to be a doc ever since I can remember. All of my education was a direct continuity to accomplish that."

In pursuit of his goal, he completed his bachelor's degree in pre-med at Johns Hopkins University, graduating in 1964, followed by graduate work in biology at the University of Louisville during 1964-66.

He obtained his medical degree from the University of Kentucky in 1970, graduating in the same class with two KMA past presidents, Drs Ardis Hoven and Preston Nunnelley. Dr Mitchell then returned to Baltimore and Johns Hopkins Hospital to serve his internship and one year of surgical fellowship. In 1972 he came back and joined Dr Hiram Polk at the University of Louisville and completed a surgery program in 1975. He served two years in the US Navy, as a ship's surgeon on a carrier for a year, after which he was an attending surgeon at the Portsmouth Naval Hospital in Virginia, teaching residents. In 1977, he returned to his ancestral roots and began a private practice of medicine in Richmond.

"My two years at Johns Hopkins and three years with Dr Polk at U of L were rigorous," he said. "In my opinion, for advanced medical training you should go to the place where you see the most, do the most, and where you have the best supervision and the best experts to advise you and be your role models. That doesn't come without a pretty high price in time, effort, and physical strain. I wonder as time goes on and modifications are made in residency programs if there is a happy medium between a rigorous residency where you are on call 24 hours a day and a 'two-end touch residency' where you are only on every seventh night, and if you get tired then you can go home — which to me is a square circle thing. . . . I'm tired, take a number.'"

Several physicians have influenced his life. Among those were his cousin Dr Harold Moberly of Winchester, and uncles Drs William Clouse and Thomas Clouse, both now deceased.

"I entered medical school wanting to be a psychiatrist, but the influence of my uncles and cousin, all surgeons, plus the strong surgical faculty at U of K — Dr Ben Eiseman was chief of surgery, Dr Lester Martin, Dr Ward Griffin — a bunch of good

guys were there, changed my mind. Dr Griffin was certainly one of my mentors, a very positive influence.

"I had made the commitment to surgery before I met Hiram Polk, but when Dr Polk came in 1972 to effectively revamp the program at the University of Louisville, I was recruited to be one of his residents. Dr Polk was always a very positive influence on me, and certainly he was one of the major factors on how I do things surgically."

Hobbies & Interests

"For a few years I restored 1965 Mustangs. I enjoyed being around a garage, but my father would never let me work in one when I was a kid because of the danger to my hands." It must have been a case of 'father knew best,' because Dr Mitchell allowed, "After restoring and selling 29 Mustangs, I finally stopped the restorations . . . because I feared the danger to my hands."

Even with his busy surgical practice and other commitments, Dr Mitchell finds time to unwind by playing golf. He is also very active in the Presbyterian Church, currently serving as a Deacon and on the Board of Deacons. Among other community activities, he serves on two commissions related to the nerve gas incinerator proposal for Madison County. One of the commissions was appointed by then Governor Brereton Jones to look into the status of the project as it goes forward, with a request that all of the members be circumspect about the project.

Personal

Dr Mitchell's family is the cornerstone of his life. He married his childhood sweetheart, Winifred, or "Winnie," as he affectionately calls her. "I never really dated anyone else — we met at 13 and dated until we married at 21."

They celebrated their 33rd anniversary on September 12.

The couple has two sons and a daughter. Dr Mitchell speaks proudly of his family. "Our oldest son, David, earned a fine arts degree from the University of Kentucky. Following graduation, he worked in logging for a year in New York state and earned enough money to spend six months in India where he met and married a girl from France. He's now completing graduate work in art therapy at Leslie College in Cambridge, Massachusetts. His wife is an artist of some merit in Boston. Ellen, our only daughter, lives in Eugene, Oregon, and is married to a student of landscape architecture. She just returned from completing international studies in Japan. Our youngest son, Clay, will be a freshman at the University of Kentucky next year." Dr Mitchell chuckled as he concluded his comments about their children, "I guess we're like most parents, just proud of every time they breathe."

The Presidency

Dr Mitchell is proud to be a part of the KMA team — THE organization that builds bridges connecting Kentucky physicians. It is not his intent to "reinvent" the organization. "To see an organization that is unified and effective become even more unified and more effective by the end of my tenure will leave me with a feeling that my year as President was a success."

When asked how he wants to be remembered as KMA President, Dr Mitchell stopped for a moment, then thoughtfully replied, "To simply be remembered as a person who made sure that everyone had a chance to have their say, who heard everyone when they had their say, and was able to convert all those different opinions into one effective statement of purpose."

— Sue Sharp
Managing Editor

THE DECLINE OF CIVILITY: The Coarsening of America

"All I want of you is a little seevility, and that of the commonest god-damnedest kind," (Attributed to the mate of a whaling ship said to his cruel captain.)

It is an axiom that civilized society, in order to remain stable and viable as an entity, is predicated upon moral, ethical, and civil standards of conduct. These standards of conduct which dictate how one individual relates to another, within that society, are usually defined by traditional, judicial, religious, or philosophical codes. The most heinous crimes of intolerance, war, and genocide in this century, for example, have been perpetrated by societies wherein criminality toward groups or individuals was tolerated if not condoned by subtle alterations in the perception of these codes of conduct. Erosion of morality and social conscience typically is insidious, and therefore prone to be tolerated and easily rationalized by a thin veil of legitimacy and expediency. Such an erosion appears to be underway in our American culture and society, heralded by an implacable decline in civility towards one another at all levels of personal and professional intercourse.

In our young country, our independence was won, in part, on the prerequisite of rejecting hide-bound traditions of societal and moral conduct such as existed in Europe or Asia at the time. The Age of Reason guided the philosophy of the accepted nature of moral behavior towards our fellow man and indebtedness to society and government. A strong Judeo-Christian ethic, a reverence for the wisdom of

the Classics, and the heritage of Roman Law and parliamentary government left little doubt for each individual regarding what was acceptable civil conduct and what was to be abhorred. Furthermore, the isolation and interdependence of peoples in a new land initially demanded a cohesion of social bonding, mutual respect, and support seldom called upon today. The compassionate philosophy of "our brother's keeper" has been overshadowed by a cynical "in your face, me first" ethos. The decline of civility has a multifactorial etiology and remains to be fully explained, let alone acknowledged. Certainly, the dislocation of traditional values and ethics owes much to the precipitous revolutions in science, industry, and technology as well as deepening cynicism spawned by calamitous foreign wars, the growing irrelevance of orthodox religion, and a distrust of a burgeoning central government. Moreover, the legitimate rejection by many of us in the 1960s of the hypocrisy of traditional morality and authority culminated in a scorched-earth policy that left a moral vacuum yet to be satisfactorily resolved. Respect for institutions, authority, family, and the individual has approached a nadir that would have been incomprehensible to our forebears.

The breakdown in civility today can be observed at all levels of social intercourse, whether in the conduct

of government and political campaigns, the products spewed forth by the entertainment industry, corporate or individual business transactions, everyday language, or violence in the streets, schools, or homes. Sadly, it can be witnessed

"The moral code of a physician as compassionate care giver to his patient is intrinsically evident; as a professional, the physician's conduct towards peers or subordinates should be beyond reproach."

daily in the dialogue and conduct between attending physicians and residents, student, nurse, or technician; or between the physician, patient, and family. Such transgressions of mutual respect, tolerance, and civility, furthermore, go both ways, with no one solely the transgressor or the aggrieved. Of fundamental importance, is the necessity for a personal code of

“We have been granted the purposeful opportunity by virtue of the trust given to us by those whom we care for to set the standards of personal conduct as well as exemplify the respect for the individual, and for life itself.”

conduct as well as accountability for one's actions. Accountability can be enforced by civil laws, social approbation, or a belief in one's God, but a personal code, whatever the well-spring, is self-regulatory and self-correcting. A personal code can not be subject to the whims and fallacies of social, philosophical, or political trends, or to expediency. The moral code of a physician as compassionate care giver to his patient is intrinsically evident; as a professional, the physician's conduct towards peers or subordinates should be beyond reproach. Admittedly, we all fail in these at one time or another. However, we have been granted the purposeful opportunity by virtue of the trust given to us by those whom we care for to set the standards of personal conduct as well as exemplify the respect for the individual, and for life itself.

The cherished image of the physician among the public has suffered enormously over the last several decades, partially due to the aforementioned ubiquitous cynicism, but also in part due to our negligence in regarding the patient and family as suffering, anxious beings. Invariably, the technology boons achieved have lessened the patient to sets of numbers, monitored parameters, complex graphics, problem solving lists, and APACHE scores. The patient simply wants reassurance, a hand held, five extra minutes, a little civility even of the “commonest goddamnedest kind.”

Jaroslav P. Stulc, MD

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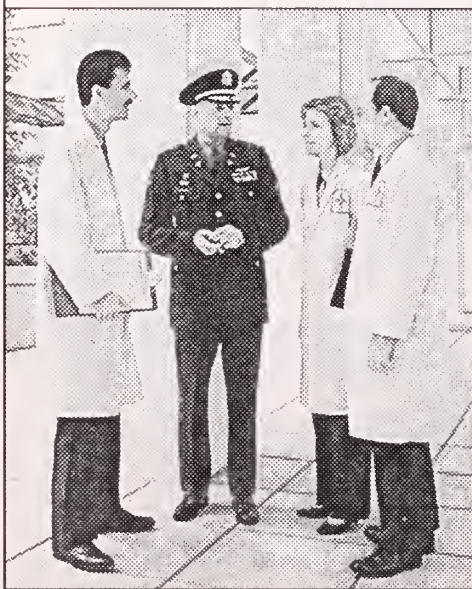
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"Physicians and their families of today helping physicians and their families of tomorrow."

Eloise Meigs is the AMA-ERF chairman of the Boyd County Medical Society Alliance. A human dynamo, she is responsible for the past 13 years for Boyd County Alliance's being first in Kentucky and in the top five of over 700 organized county Alliances in the nation in donations to the American Medical Association Education and Research Foundation. The KMA Alliance forwarded \$52,300 to AMA-ERF this past year, over \$20,000 of which was donated in Boyd County alone.

Mrs Meigs' (Lamar) motto is: "Physicians and their families of today helping physicians and their families of tomorrow." In order to breathe life into that lofty belief, she establishes personal contacts with all physicians in Boyd County and solicits their contributions as well as those of their spouses. She lets physicians know that their annual contributions to their medical schools can be facilitated through AMA-ERF.

In addition to designating the medical school, donors may be specific in their gifts' use: for instance, in the unrestricted Medical School Excellence Fund, the Medical School Assistance Fund (for scholarships), the Development Fund (for pilot programs in health and medicine), or the Categorical Research Grant Fund (for research in specific areas). All contributions are tax deductible.

Regarding the importance of financial assistance: Can you guess the mean indebtedness for medical school students upon graduation? It's \$60,000, according to James Thompson, MD, Chair of the AMA Section on Medical Scholarships. Realizing the financial difficulties

facing medical schools and students, the AMA established the nonprofit AMA-ERF in 1950. Since that time, over \$63 million has been contributed to medical schools throughout the United States.

As for the significance of research, we need go back no further than Hippocrates, who stated: "The aim of mankind is to die young as late as possible."

The success of Medical Alliance



Boyd County Alliance members L to R, Glenna Lett, Juanita Kozee and Eloise Meigs.

fund-raising hinges on the commitment, dedication and resolve of Alliance members like Eloise Meigs. She shuns credit for the tremendous job she has done, explaining that the real praise should be reserved for the Boyd County physicians and their spouses who, by giving so generously, personify the concept that contributions to AMA-ERF are more than just charitable donations; they are a legacy from one generation of medical professionals to



Ruth Ryan

the next and an investment in the health of generations to come.

To contribute, please make check payable to AMA-ERF. Specify, if you wish, the medical school and even one of the four categories of use.

Send to: Mrs G. I. (Carolyn) Daley, AMA-ERF Chairman, KMA Alliance, 118 Campbell Drive, Apt 102, Hazard, KY 41701.

Ruth Ryan
KMAA President

Carpal Tunnel Syndrome

I read with interest Dr Kasdan's article in the July 1996 issue of the *Journal of the KMA* on carpal tunnel syndrome and worker's compensation. I noticed that there was no comparison between the worker's comp and non-worker's comp groups regarding the types of environments to which the patients were being returned. It is naturally going to take longer for a worker doing moderately heavy work to get back to work than it is for a sedentary or nonworking patient. The costs may also be higher because of higher wages heavier occupations may enjoy. The comparability of the two groups used in the study (and in many similar studies) regarding the types of work the two groups do is not addressed and may not be entirely comparable, reducing the scientific credibility of the study. Thus the workers' comp system may not be entirely to blame for higher costs, although no doubt it is contributory.

Paul D. Forrest, MD

The authors' reply —

We appreciate Dr Forrest's comments regarding our article published in the July 1996 issue of the *Journal of the Kentucky Medical Association*. Dr Forrest's comments were certainly related to the level of postoperative activity. That is, did the patient's environment, whether it was workers' compensation or nonworkers' compensation, affect the return to work? Other studies have addressed the issues of work relatedness.^{1,2,3} Very little information is available currently in the form of prospective studies with control groups on the amount of time it takes to get patients back to work, depending on the type of activity.

We certainly agree that the more

physically demanding jobs may keep individuals away from their regular work for longer periods of time. The secondary increases in costs are certainly associated.

The purpose of our study was not to replicate these previous efforts. Instead, we focused very specifically upon the effects of workers' compensation and litigation on the physicians who manage these patients. The questionnaire portion of our study related directly to treating surgeons' subjective impressions regarding the relationship of litigation to patient outcome. The second portion of the study related more directly to the title of the paper. Its purpose was to demonstrate what, if any, effect litigation had on physician workload.

Michael I. Vender, MD
Hand Surgery Associates, SC
637 East Golf Road, Suite 206
Arlington Heights, IL 60005

Morton L. Kasdan, MD
PO Box 6048
Louisville, KY 40206

References

1. Lister GD. Ergonomic disorders. *J Hand Surg.* 1995;20A:353.
2. Vender MI, Kasdan ML, Truppa KL. Upper extremity disorders: a literature review to determine work-relatedness. *J Hand Surg.* 1995;20A:534-541.
3. Weiland AJ. Repetitive strain injuries and cumulative trauma disorders. *J Hand Surg.* 1996;21A:337.

Genetic Disorders Article

I was pleased to see the article entitled "The Prevalence of Genetic Disorders, Birth Defects, and Syndromes in Central and Eastern Kentucky" by Cadle, Dawson, and

Hall in the June 1996 edition of the *Journal of the Kentucky Medical Association*. However, the article begs several questions that were not adequately addressed.

First, what is the estimated regional population that is serviced by the University of Kentucky Chandler Medical Center Division of Genetics and Dysmorphology? This would allow one to estimate frequency of the individual genetic diseases in the general population.

Second, according to Table 7, Marfan Syndrome is the 4th most common specific overall genetic diagnosis. If this is so, then this is a very interesting observation since the autosomal dominant disorder has an estimated frequency of 1/10,000. On the other hand, if findings are incorrect, then why might this be so? Are Marfan-related syndromes erroneously being misdiagnosed? And how many clinical diagnoses have been verified with molecular analysis of the fibrillin 1 gene?

Third, because some common multiple congenital anomaly syndromes are also chromosomal anomalies (eg, Downs Syndrome), and some common multiple congenital anomaly syndromes also teratogenic diseases (eg, fetal alcohol syndrome), then different syndromes sometimes appear in different categories. It therefore may have been better to instead categorize findings as to whether they were chromosomal, monogenic, multigenic, or teratogenic. Additionally, the subcategory of *genetic counseling* in Table 1, although common, is not a disease and does not belong in any category.

Patrick Hess, PhD

The author's reply —

Dr Hess asks several good questions. The population served by our division at the University

of Kentucky is about 1.7 million. While this figure is useful, it really does not allow the accurate determination of the frequency of any particular genetic disorder. The frequency could be determined if we were evaluating *every* patient in our population who had a particular disorder. This, of course, does not happen. First of all, stillborns and infants who die in the neonatal period with genetic disorders are often (usually) not seen by a geneticist and therefore not diagnosed. Secondly, most genetic disorders are variably expressed, and those who are affected to only a minor degree may never be diagnosed. This is often the case with Marfan syndrome.

The estimated frequency of

Marfan syndrome is not 1/10,000. It is now thought to be 1/3000 to 1/5000.¹ Even though Marfan syndrome is the fourth most common overall specific diagnosis in our population it is clearly *under-diagnosed*. Very few of our patients with Marfan syndrome have been diagnosed molecularly since this is a relatively new technology and our study spanned the past 15 years.

There were several possible ways to categorize our data, and Dr Hess' suggestion of categorization based on etiology is a reasonable one. Categories for chromosomal and teratogenic etiologies were used.

Finally, the tables generated in this study reflected genetic diagnoses. "Genetic Counseling" as a diagnosis is legitimate and common. If we see a

couple for preconceptional genetic counseling because of their concerns about a relative with Prader-Willi syndrome, we cannot tally that as a patient with Prader-Willi since we did not actually see that patient. We can only categorize that patient encounter as "Genetic Counseling."

Ronald G. Cadle

References

1. Pyeritz RE. Disorders of Fibrillins and microfibrillogenesis: Marfan syndrome, MASS phenotype, contractural arachnodactyly and related conditions. In: Rimoin DL, Connor JM and Pyeritz RE, eds. *Principles and Practice of Medical Genetics*, 3rd ed. New York: Churchill Livingstone, in press.

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PEOPLE

Lelan K. Woodmansee, CAE, executive director of the Jefferson County Medical Society, was recently inaugurated as President of the American Association of Medical Society Executives. During his tenure Woodmansee will lead AAMSE through a survey of its 1,200 members nationwide. At the same time a Futures Committee will identify emerging trends affecting medical societies, and the data will be used for a strategic planning update in April 1997. Woodmansee also has appointed a Collaborative Relationships Task Force to highlight ways AAMSE members at state and county medical societies; local, state and national specialty societies; and the AMA can work together to better serve their members.

John J. Buchino, MD, Louisville, recently was elected president of the Society for Pediatric Pathology. Dr Buchino is chief of pathology at Kosair Children's Hospital, Louisville, and professor of pediatrics and pathology at the University of Louisville School of Medicine.

UPDATES

Surgeon General's Report on Physical Activity and Health

The first Surgeon General's Report on Physical Activity and Health was issued in Washington, DC, in July. The Report documents the large volume of scientific and medical evidence on the negative health consequences of physical inactivity. Large percentages of the American population, including those in Kentucky, lead an inactive or sedentary lifestyle. The American College of Sports Medicine was the coordinator of the consortium that prepared the information for the

Surgeon General's Report.

W. Ben Kibler, MD, First Vice President of the American College of Sports Medicine, and Medical Director of the Lexington Clinic Sports Medicine Center, Lexington, is available to address inquiries on the Report.

Kosair Pediatrics Center Opens

The Kosair Charities Pediatrics Center in Louisville opened on August 5 and became fully operational on August 15, when the Child Evaluation Center (CEC) moved into the first two floors. The CEC provides genetic testing, evaluation, and treatment services for families of children with special needs.

"For the first time," said **Larry N. Cook, MD**, University of Louisville pediatrics chairman, "the majority of the Department of Pediatrics faculty is under a common roof. This modern, magnificent building will unquestionably enhance the morale, the image, and the productivity of our department."

The facility will be called the Dorothy K. Brecher Pavilion in recognition of her \$1.1 million bequest. Additional funding for the Kosair Pediatrics Center came from a \$2.5 million Alliant Health system grant and a \$1.5 million grant from Kosair Charities, the philanthropic arm of Kosair Shrine Temple. CEC director, **Bernard Weisskopf, MD**, said, "What this means to the Child Evaluation Center is a permanency within the university and within the community."

FDA Clearance for Merrem®

Zeneca has announced that the Food and Drug Administration (FDA) has cleared the new broad-spectrum intravenous antibiotic MERREM® I.V. (meropenem for injection) for use in treating adults and children with

certain serious bacterial infections. According to the announcement, MERREM is indicated in the US for the treatment of complicated intra-abdominal infections in adults and pediatric patients and for the treatment of bacterial meningitis in pediatric patients.

Booklet On Alzheimer Disease Available

Physicians may want to suggest to family members or other care givers a new, illustrated, 48-page booklet published by the National Institute on Aging entitled *Alzheimer's Disease: Unraveling the Mystery*. Written for nonscientists, the booklet describes in simple terms the basic anatomy of the disease and how it affects the brain. In addition to helpful anatomical drawings and brain images, the booklet includes discussions of known and suspected risk factors, current diagnostic tools, and potential biomedical treatments. A glossary of terms and suggestions for further reading also enhance the booklet's usefulness. To obtain a free copy, call the Alzheimer's Disease Education and Referral (ADEAR) Center at 800/438-4380.

Solid Tumor Oncology Education Foundation To Offer Free Educational Services

Responding to a critical need among cancer-care professionals for current, authoritative clinical information, the newly formed not-for-profit Solid Tumor Oncology Education Foundation has announced that it is offering free educational programs to community-based oncologists and other health-care professionals, according to a recent report from the Foundation.

The Solid Tumor Oncology Education Foundation was established in 1996 to provide physician

education, with the express goal of improving the quality of care for cancer patients with the most common solid tumors.

The Foundation's report stated that its planned series of *local* seminars and audioconferences will be led by a faculty of expert physicians. The programs will focus on breast, colorectal, gastrointestinal, genitourinary, gynecologic, pancreatic, and lung cancers — the topics of interest most often cited by interview participants — along with adjuvant and palliative therapy, current and new protocol regimens, screening and diagnosis, and quality-of-life issues.

Two convenient program formats will be available in the Fall of 1996. The first consists of a series of presentations conducted at local, state, and regional oncology meetings by leading oncologists. At each presentation, participants will receive a digest of the key clinical information covered at the session. Participants also will have an opportunity to ask questions and discuss pressing cancer treatment issues, including their own challenging clinical cases, with the faculty. Letters announcing the visiting faculty lecture program will be distributed to officers of state oncology societies.

The second format will be telephone audioconferences, allowing health-care professionals to participate from their home or office sites. The audioconferences also will provide an opportunity for interactive discussion. Potential participants will be notified of the programs by brochures, which will outline the topics and schedule for sessions.

The visiting faculty lecture series and audioconferences will focus on disease-specific diagnoses, patient management, therapy selection, medical outcomes, and quality-of-life issues.

The formation of the Solid Tumor Oncology Education Foundation was

made possible by an unrestricted educational grant from Lilly Oncology. Health-care professionals can learn more about the not-for-profit organization and its services by calling 1-800/223-8978.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Barren

Alecia E. Graves, MD — OBG
1216B N Race St, Glasgow 42141
1992, U of Louisville

Boone

Sheila C. Harmeling, MD — PD
7348 US Hwy 42, Florence 41042
1992, U of Kentucky

Gallatin

Francis Beng Kiat Ong, MD — FP
1524 Coppercreek Ct, Florence 41042
1978, U of Toronto

Jefferson

Dawn L. Falco, MD — AN
711 Highwood Dr, Louisville 40206
1991, U of Louisville

John E. Haas, MD — AN
4033 Elmwood Ave, Louisville 40207
1991, U of Louisville

Pragna R. Jadav, MD — IM
4109 Waterford Cir Ste 1, Louisville 40207

1965, B. J. Medical, India
Amy L. Johnson, MD — P
1807 Tyler Pky, Louisville 40204
1985, U of Kentucky

Warren E. Milteer, MD — IM
9616 Dixie Highway, Louisville 40272
1985, Commonwealth, Virginia

Brett M. Ryabik, MD — P
1350 S 6th St, Louisville 40208-2251
1990, U of Kansas

Laurel

Anis G. Chalhoub, MD — C
1406 W 5th Ste 3, London 40741
1985, St Joseph, Lebanon

Madison

Kent J. Kessler, MD — S
789 Eastern Byp Ste 23, Richmond 40475

1991, U of Louisville
Benjamin H. McQuaide, MD — R
229 Eric Dr, Richmond 40475
1991, U of Louisville

John D. Rogers, MD — C
793 Eastern Byp Ste 3, Richmond 40475-2408

1990, Chicago Medical School
David J. Shafran, MD — U
108 Shamrock Ln Apt 4, Richmond 40475

1990, Case Western Reserve U

Pike

Douglas W. Lamppin, MD — OTO
151 Combs Dr, Pikeville 41501
1963, Tulane

Shelby

Ronald Edwin Walldridge, MD — FP
60 Mack Walters Rd, Shelbyville 40065
1993, U of Louisville

Warren

Keith E. Dyer, MD — PMR
1890 Lyda Ave Ste 103, Bowling Green 42104

1990, U of Texas, Galveston

DEATHS

Donald M. Stevens, MD
Alexandria
1921-1996

Donald M. Stevens, MD, a retired general practitioner, died June 26, 1996. A 1952 graduate of the University of Cincinnati College of Medicine, Dr Stevens was a life member of KMA.

**William C. Hambley, MD
Pikeville
1914-1996**

William C. Hambley, MD, a retired general surgeon, died August 23, 1996.

Dr Hambley served as mayor of Pikeville for 30 years, from 1960 to 1990. He gained national attention for his skill in enlisting federal officials to help him fulfill his dream of moving the Big Sandy River out of downtown Pikeville. The resulting "cut-through" was the second-largest land removal project in US history after the Panama Canal.

Dr Hambley also secured government funds to develop Pikeville as a "model city," a program that provided much-needed housing, parks, and the Model City Day Care Center.

He graduated from Northwestern University Medical School in 1944 and was a life member of KMA.

**Terrell D. Mays, MD
Knoxville, TN
1937-1996**

Terrell D. Mays, MD, an OB-GYN, died September 2, 1996. Dr Mays graduated from the University of Louisville School of Medicine in 1963 and was an associate member of KMA.

**J. Patrick Sutherland, MD
Louisville
1932-1996**

J. Patrick Sutherland, an OB-GYN, died September 2, 1996. A 1958 graduate of the University of Louisville School of Medicine, Dr Sutherland was an inactive member of KMA.

**Louise F. Hutchins, MD
Berea
1911-1996**

Louise F. Hutchins, MD, a retired pediatrician and gynecologist, died September 3, 1996.

For nearly 50 years, Dr Hutchins was medical director and board president of the Mountain Maternal

Health League in Berea, established to improve the health of rural Appalachian families. From about 1939 to 1967, Dr Hutchins was Berea's only pediatrician. For years, without pay, she provided pediatric services through the Berea College Hospital. She also served as the college's student health physician.

Dr Hutchins was instrumental in establishing the Family Plan Clinic at Berea College Hospital in 1944, and she served as chairman of the Madison County Board of Health. In 1967, she gave the first speech on contraception to the Kentucky

Medical Association.

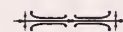
For her work, Dr Hutchins received many honors. Among them, the Lane Bryant Award for Distinguished Volunteer Service; the Margaret Sanger Award from the Planned Parenthood Federation of America; and the Kentucky Public Health Association's Helen B. Fraser Award for outstanding service on behalf of mothers and children. She was named Kentucky Woman of the Year in 1991.

Dr Hutchins graduated from Yale University School of Medicine in 1936 and was a life member of KMA.

KMA-OMSS ANNUAL MEETING

The annual meeting of the KMA Organized Medical Staff Section will be held October 25-26, 1996, at the Rudd Heart and Lung Center Jewish Hospital, Louisville. OMSS representatives, chiefs of medical staffs, and administrators are encouraged to attend.

The Friday evening session will focus on medical care management, featuring Keynote Speaker Lee H. McCormick, MD, Immediate Past Chair of the AMA-OMSS. Saturday will include a look at JCAHO activities, the changing role of the medical staff, and "hot" issues in managed care from a "how to" perspective, as well as the OMSS business meeting.



For additional information, contact John O'Brien, MD, KMA-OMSS Chair (502)629-3843, or Bob Klinglesmith, at the KMA office (502)426-6200.

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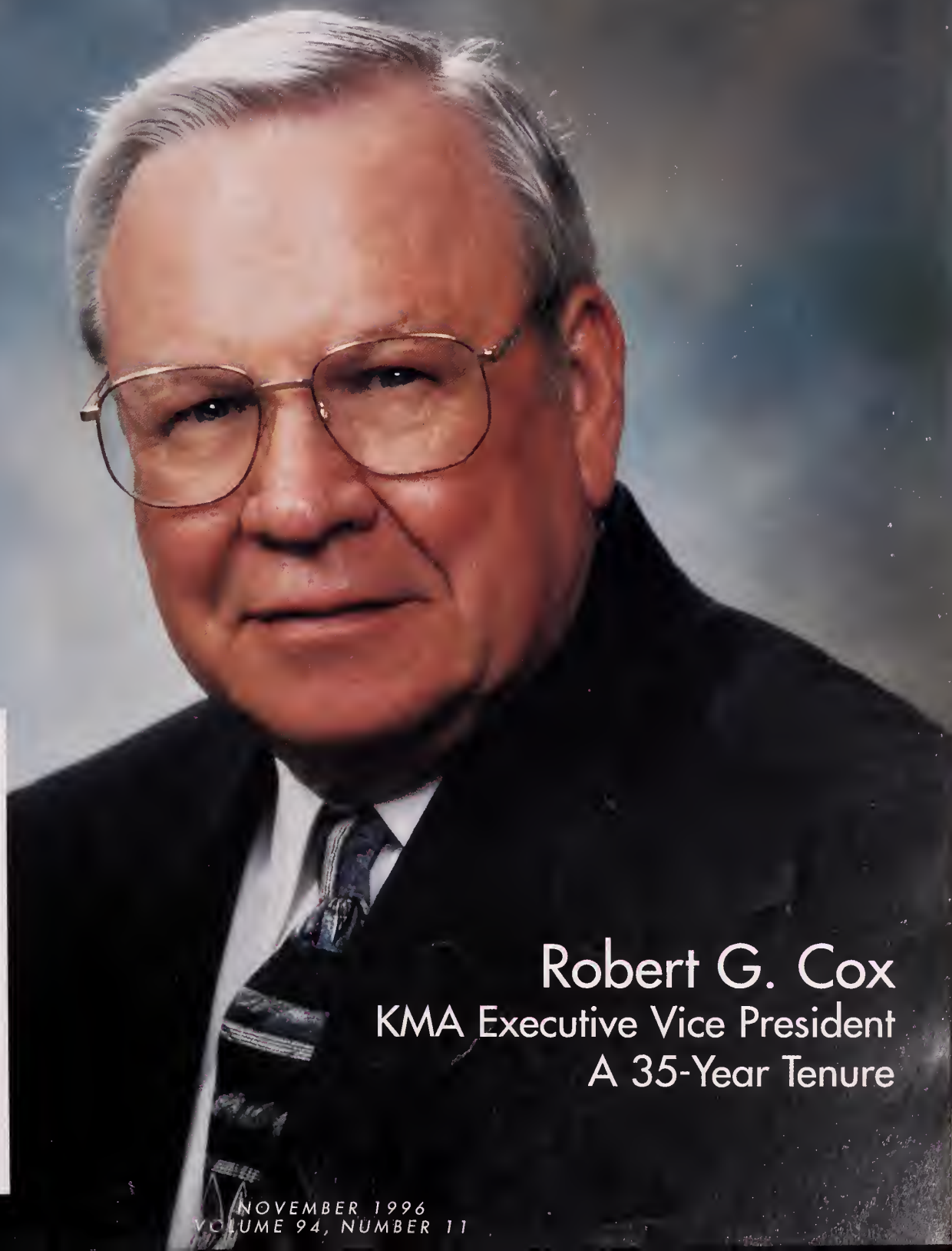
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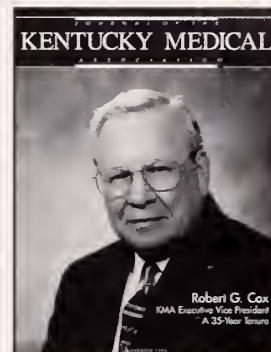


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| | | |
|--------------------|--------------------------------------------------------------------------------------------------------------------------------------|-----|
| COVER STORY | Robert G. Cox — Reflections on 35 Eventful Years as KMA's Leader | 482 |
| | A Personal Profile of Bob Cox | 487 |
| SCIENTIFIC | Pulmonary Coccidioidomycosis in Kentucky <i>John H. Woodring, MD; Marcus L. Dillon, MD</i> | 490 |
| | Trigger Finger: Not Always Work Related <i>Morton L. Kasdan, MD, FACS; Valerie M. Leis; Kathleen Lewis; Ann S. Kasdan, RN</i> | 498 |
| | Pancoast's Syndrome Secondary to Thoracic Actinomycosis <i>Arthur Tolentino, MD; Sunket Ahkee, MD; Julio Ramirez, MD</i> | 500 |
| EDITORIALS | THINK — About Tunnel Vision <i>Carolyn D. Burns, MD</i> | 503 |
| ASSOCIATION | <i>Monitoring Medicine</i> | 477 |
| | Physician's Recognition Awards | 506 |
| | News | 508 |
| DEPARTMENTS | President's Page | 475 |
| | Advertisers' Guide | 512 |
| | Alliance Page | 505 |
| | Book Reviews | 504 |
| | Classifieds | 510 |



COVER: Robert G. Cox, CEO of the Kentucky Medical Association, is retiring following a 35-year tenure. His personal message to the KMA membership is on page 475. The JKMA interviewed Bob Cox on KMA accomplishments over the past 35 years, and what he foresees as the future for the Association. See cover story on page 482.

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Dear KMA Members,

I didn't know retirement immediately followed the orientation program . . . but it sure seems that way. The editors, who have done such a great job over the years with our publication, have kindly allowed me to use the medium of the *KMA Journal* to extend my best wishes to every KMA member. It has been a pleasure and honor to serve as Executive Editor of the *Journal* and as KMA Executive Vice President since April 1968, a little more than 28 years. Hired in July 1961, KMA has been my life since.

Remembering that employment interview with my predecessor, Joseph Sanford, recalling the KMA leadership and staff of the 60s, recollections of specific occasions in my career . . . it seems like yesterday. Dad always told me how fast time passed us by, and now I really understand what he meant.

Let me take this opportunity, with daily deadlines aside, to reminisce over the past 35 years. I have seen startling transformations in medical technology, dramatic advances in the delivery of medical care, and vast changes in the day-to-day operation of physicians' practices. One constant has always been there, though — giants in Kentucky medicine who have always surfaced in dark times of turmoil to lead the profession.

It has been my privilege to work closely with hundreds of physicians, knowing thousands by name, and developing lifelong friendships with many now gone, yet with many of you still here to share in the future. KMA has been my life, its members my friends, its achievements my thrills. Occasionally there was a little letdown when we fell short of our self-imposed goals. It has been a career I would never want to change . . . and created memories I shall never forget.

I thank each of you for giving me the opportunity to serve. I leave knowing there is a great and experienced staff to build on the tradition that has brought KMA to where it is today. Kay and I look forward to retirement much as we did each day during our years at KMA. We hope to see many of you in quieter days ahead, and we wish you happiness and good health.

Bob Cox

Robert G. Cox
KMA Executive Vice President

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MONITORING MEDICINE

NEWS FOR KENTUCKY PHYSICIANS

Governor Paul Patton is considering calling the Kentucky General Assembly into Special Session on December 2 to address Workers' Compensation. Gregory E. Gleis, MD, a Louisville orthopedic surgeon, has compiled the following for your information in preparing for the Special Legislative Session.

Kentucky Workers' Compensation — "Physicians Have Paid Their Price"

Governor Paul E. Patton has announced that he will tentatively call a special session of the legislature on 12/02/96 to consider the rising cost of workers' compensation in the state of Kentucky. Even though past legislative sessions have examined this issue, and numerous changes have been enacted into law, Kentucky is still considered a "high cost state" for workers' compensation.

Multiple reasons have been identified as contributing factors, and medical costs in particular have been identified as a significant portion of the total workers' compensation cost.

The 1994 legislative session passed House Bill 928, which mandated a "25% decrease in medical cost." HB 928 resulted in the implementation of a new medical fee schedule, which lowered the level of reimbursement compared to the prior fee schedule set in 1989. This has resulted in a 25% decrease in reimbursement compared to 1989. HB 928 also established the parameters for managed care to be instituted for workers' compensation. The result has been that some managed care systems are requesting physicians to take a further discount on the new 1994 fee schedule.

However, as the Kentucky Medical Association's legislative counsel, Mr William E. Doll, so ably stated in the 5/16/96 remarks to the Workers' Compensation Advisory Council (see Monitoring Medicine in June 1996 JKMA), Kentucky physicians have "paid their price in workers' compensation reform, and further reforms of the system should not negatively impact the physicians in Kentucky."

Your legislator needs to be informed about the medical issues of workers' compensation.

The medical profession has been a convenient scapegoat in the past and continues to be an easy target, despite the fact that reimbursements are now below 1989 levels for comparable problems. Now it is time to address the other cost drivers, especially increased utilization.

In preparation for the special session, we need to contact our representatives—we must convince them with evidence that the Kentucky physicians do not need further mandates for fee reductions or other medical reforms to complicate the care of injured workers. With the following evidence, physicians should be able to convince your legislators that Kentucky physicians are doing a good job in managing workers in comparison to other benchmark states.

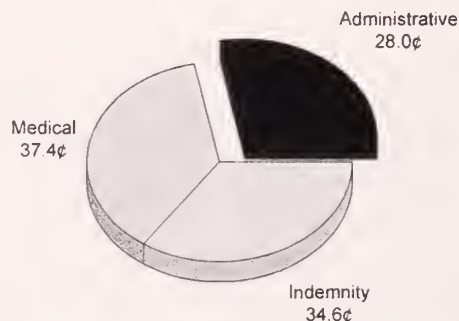
Our point is that the Legislative Special Session should look at other areas of workers' compensation for reform in order to lower the overall cost of workers' compensation in Kentucky.

According to the Workers' Compensation Advisory Council's initial report, the principle culprit precipitating astronomic growth in Kentucky's Workers' Compensation cost has been use of the system itself. According to page six, "Medical inflation and the extent and duration of injury . . . pale as cost drivers in comparison to escalating utilization of the system."

More information comes from the National Council on Compensation Insurance, Inc (NCCI) *Kentucky Closed Claim Study* from 3/94. NCCI is a licensed workers' compensation statistical agent in Kentucky,

JKMA

Distribution of Workers' Compensation Premium Dollar



Based in part upon NCCI - 1994 Closed Claim Study data.

Kentucky Department of Workers' Claims
Prepared February 28, 1995

Fig 1

funded by the insurance companies. They claim to have the "most complete and accurate database on state workers' compensation characteristics."

For physicians to effectively educate legislators on this issue, we must be able to explain "where the premium dollars go." Based upon the Kentucky Department of Workers' Compensation Claims, the distribution based upon the premium insurance dollar (Fig 1): medical costs are 37.4%, indemnity costs 34.6%, and administrative costs are 28%. Of the medical costs, 47% were for hospital based costs, 39% for non-hospital based services (such as physicians, chiropractors, physical therapists, and outpatient radiology), 4% were for pharmacy costs, and 10% were "other" which includes medical rehabilitation and independent medical exams, etc.

So out of the total premium dollar, the nonhospital services including physicians account for 14.6% ($37.4\% \times 39\%$) of the dollars. This 14.6% is based upon 1994 data, which has been even further reduced because of HB 928's mandated 25% fee schedule changes.

Two independent consultants to the Kentucky Department of Workers' Claims, Medicode, a Salt Lake City consulting firm, and Workers' Compensation Research Institute, both confirm that new fee schedules have "reduced medical reimbursement by 25%." This is proof that physicians have "paid the price" in workers' compensation reform.

Medicode has reported that, in addition to the 25% savings from the fee schedule, predicted savings are coming from utilization review as well as savings from implementing managed care. These additional savings have not been fully realized only because of their recent implementation. According to Medicode itself, "The savings will likely well exceed the goal of 25%."

Besides the question of whether a crisis exists, we should know how we compare to our neighboring states. Based upon Fig 2, Kentucky is the highest in net insurance cost with Virginia ranked best at #1, Indiana ranked #2, and South Carolina ranked #3.

The following tables are taken from the NCCI 1994 Closed Claim Study. An important caveat of the

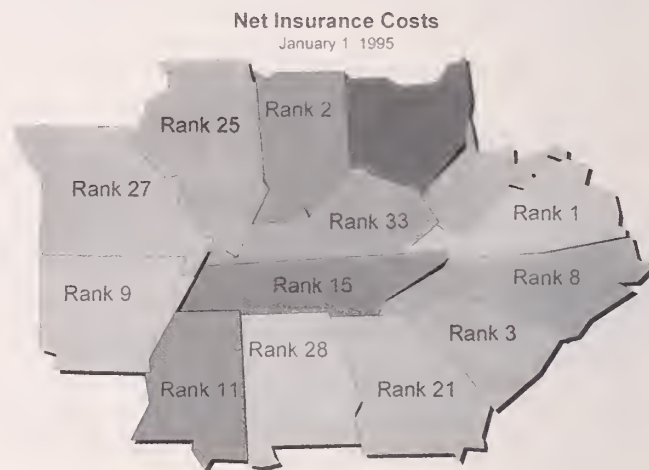


Fig 2

NCCI report is that it excludes coal mine claims.

NCCI Table 24 (Fig 3) indicates the length of indemnity payment — wage replacement for time off work. Kentucky compares very favorably to benchmark Virginia which has an average temporary benefit duration of 119 weeks versus Kentucky's 58 weeks. South Carolina, which is #3, is only slightly shorter at 53 weeks. This is an indirect measurement of the length of times that Kentucky's physicians keep employees off work since temporary benefits are paid while employees are unable to work.

Using NCCI Table 29 (Fig 4),

| NCCI Table 24 | |
|-----------------------------------------------|-----------------------------------------|
| Average Number of Weeks of Temporary Benefits | |
| State | Avg. Temporary Benefit Duration (Weeks) |
| NH | 122 |
| VA | 119 |
| GA | 103 |
| WI | 66 |
| MO | 63 |
| AR | 59 |
| NC | 58 |
| KY | 58 |
| SC | 53 |
| TN | 42 |

Fig 3

NCCI Table 29

| State | Avg. Impairment Rating | Avg. Final Disability Rating |
|-------|------------------------|------------------------------|
| NH | 14.1 | 16.4 |
| VA | 17.5 | 16.6 |
| GA | 16.4 | 16.8 |
| KY | 18.2 | 30.4 |
| MO | 24.7 | 27.6 |
| TN | 15.9 | 39.2 |
| NC | 20.1 | 23.3 |
| SC | 18.8 | 22.5 |
| AR | 15.9 | 23.1 |
| AVG | 18 | 24 |

Fig 4

we can judge physicians' performance and compare it to states based upon the impairment rating. The impairment rating is the residual anatomic and functional deficit resulting from the injury and by Kentucky law is required to be calculated using the AMA Guidelines to Permanent Impairment. The physical impairment rating given by Kentucky physicians is 18.2% compared to a regional average of 18.0%. So there is essentially no difference between Kentucky compared to Virginia and South Carolina.

What is striking, however, is the difference in the final disability rating. The disability rating is determined by the administrative law judge, taking into account people's physical impairment as adjusted for *potential loss of earnings*. In Kentucky, the disability rating is 30.4%, whereas in South Carolina it is 22.5%. In Virginia, the disability rating is 16.6%, which is actually less than the physician impairment rating of 17.5%. The significance of this is that the final indemnity award to the employee is determined by the disability rating, not by the impairment rating.

The Kentucky physicians are calculating impairment ratings that are comparable to the regional comparison states, whereas our administrative law judges disability ratings are substantially higher than our benchmark states of Virginia and South Carolina. They are also substantially higher than the regional average of 24.0%. Kentucky apparently takes a loss of potential earnings weighted to a much greater degree than do our comparison states.

NCCI has criticized the Kentucky Workers' Compensation system because payments for medical expenses are greater than indemnity expenses — 37.4% versus 34.6%. This is for all injuries so that for injuries resulting in no lost time from work and no impairment, there is no indemnity payment. For these no lost time employees, all of the payments are for the related medical expenses.

This is in distinction to more severe injuries where lost time occurs and results in indemnity payments. In the NCCI report, graph eight (Fig 5) indicates that in cases where indemnity payments are made, they are substantially greater

Graph 8
AVERAGE MEDICAL AND INDEMNITY COSTS
BY TYPE OF INJURY

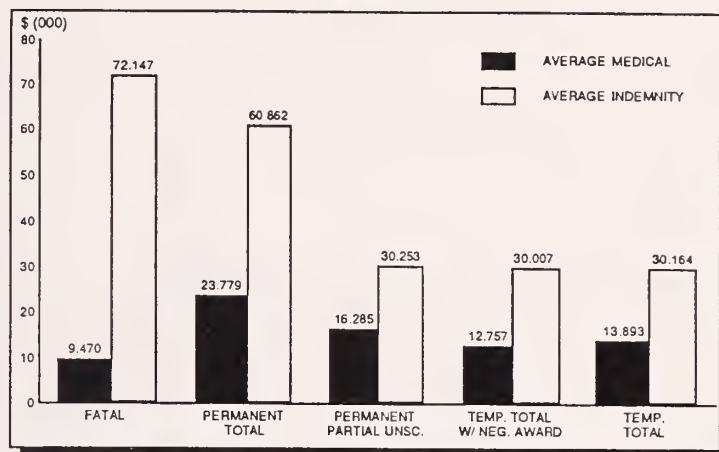


Fig 5

than the average medical expenses.

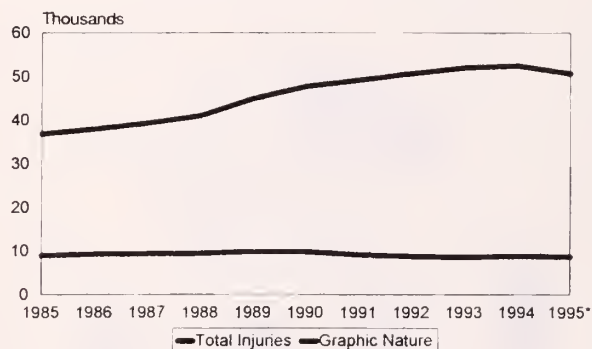
So the real culprit has been the increased use of the workers' compensation system. This is documented in the Workers' Compensation Advisory Council's first hearing on 4/18/96. The Kentucky Department of Workers' Compensations Claims graph for Lost Time Injuries (Fig 6) reported from 1985 to 1995 illustrates the increase in total injuries reported. This includes graphic injuries, which would include such injuries as fractures, lacerations, and such obvious trauma.

This is compared to the nongraphic injuries such as soft tissue strains and cumulative trauma problems. This graph illustrates that the graphic injuries between 1985 and 1995 actually decreased from 9,110 to 8,761. However, nongraphic injuries increased 51%, and an overall increase in lost time injuries also rose 38%.

This is exactly the same trend as demonstrated in the Workers' Compensation Claims Trend reported in the same testimony. Graph 7 demonstrates that from 1985 through 1994, the graphic injuries increased by only 14%,

Lost-time Injuries Reported 1985-1995*

*1995 figures projected beyond 8/95



Kentucky Department of Workers Claims, prepared 10/19/95

Fig 6

while nongraphic injuries increased by 244%. A staggering overall increase of 224% in workers' compensation claims has occurred.

These two charts demonstrate that graphic injuries, which are easily documented as valid claims, are essentially unchanged. Therefore, the significant cost driver has been the 244% increase in nongraphic "soft tissue" injuries. As long as employees continue to be claimants, physicians have to evaluate, fill out forms, document treatment plans, and interact with employers, claims adjusters, and rehabilitation coordinators.

As our KMA legislative counsel, Mr Bill Doll, has stated in his testimony, "There's your bogeyman; or maybe your scapegoat. Physicians didn't create this program; as caregivers, they are necessarily a part of it, but they are certainly not responsible for the way it works or the way it's structured."

Physicians' have "paid the price" with the new 1994 fee schedule. Comparison of Kentucky's fee schedule and other states' fee schedules can be compared to Medicare fees. Prior to 1994, the Kentucky Workers' Comp fee

schedule was at the median of all workers' compensation fee schedules. After enactment of HB 928, there was a 20% decrease in the fee schedule, resulting in Kentucky now being 20% below the median and in the five lowest states in medical reimbursement.

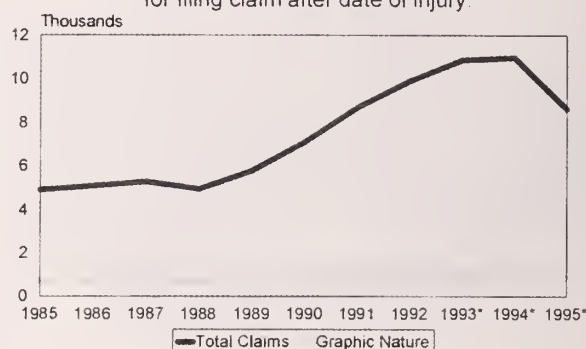
Graph 8 also compares this to Medicare reimbursement, but the complexity of cases for workers' compensation is entirely different, as discussed above. Care is therefore much more complex considering the number of "players" who interact about each patient and the amount of paperwork generated for workers' compensation. This strongly argues against workers' compensation being tied to Medicare fee schedules.

We urge physicians to discuss these points with your legislators:

1. If Kentucky wishes to be compared to Virginia, which is the #1 benchmark state, the inflation of physicians' impairment ratings in the calculation of disability needs to be controlled. In Virginia, the disability rating is actually lower than the impairment rating.
2. The definition of "injury" is a

Claim Trend re: Lost-time Injuries*

*1993-95 projected due to two-year statute of limitation for filing claim after date of injury



Kentucky Department of Workers Claims, prepared 10/21/95

Fig 7

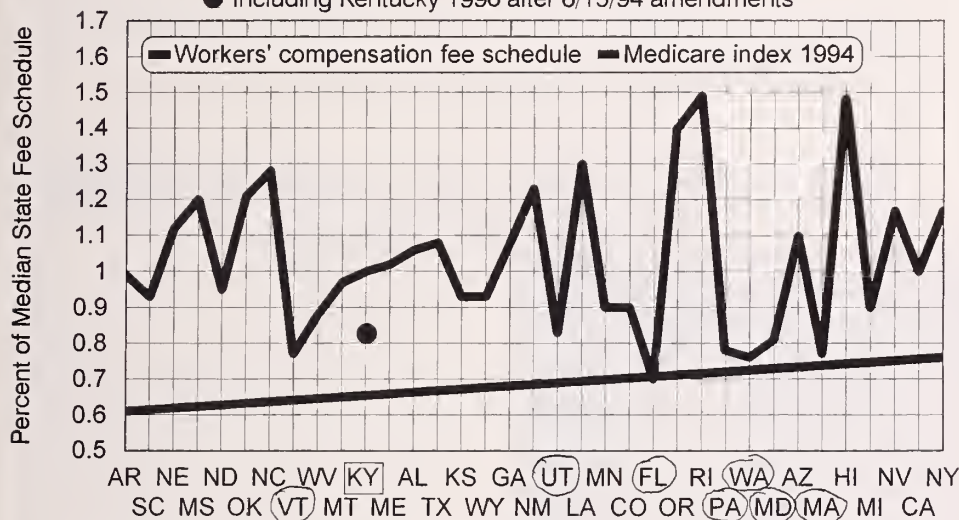
frequently discussed issue on increased utilization. For medical providers, when employees seek medical care, we need to be able to determine who is the financially responsible party. In Virginia, the workers' comp laws exclude carpal tunnel syndrome from coverage as a workplace injury.

3. Discuss that Kentucky is in the five lowest states for reimbursement in workers' compensation cases. It is 20% below the national median for fee schedules. With reduced payments, it may be difficult to find treating physicians in the future.
4. Workers' compensation fee schedules should not be tied to Medicare since the complexity to these patients is much more time consuming. Remind them of the regulations mandating the filling out of forms, documentation of treatment plans, and consultation with employers, insurance companies, and rehab coordinators.
5. Remind them that Kentucky's physicians are returning employees back to work better than average compared to its

Workers' Compensation

Fee Schedules and Medicare Fees, 1994

● including Kentucky 1996 after 6/15/94 amendments



All workers' compensation fee schedules are as of 1/1/94

Fig 8

surrounding benchmark states and significantly better than #1 rated Virginia.

6. The distribution of the insurance premium dollar for all claims range from 28% for insurance administrative costs to indemnity costs of 34.6% and medical costs of 37.4%. The criticism of high medical costs relative to the indemnity payments of wage replacement and disability awards needs to be tempered with the fact that when disability awards are made that they are much greater than the actual medical costs. In these cases which receive indemnity payment, the medical cost is only 13% to 54% of the payment made to the employee, depending upon the type of injury (Fig 5).

We need to contact our legislators and educate them:

- Because Kentucky's physicians are doing as good a job providing medical care as our benchmark states.
- Because savings of 25%, accomplished since 1994, was directly due to reduced payment to medical providers.
- Because further changes in medical payments may compromise employee access to care.
- Because increased cost of the workers' compensation system is most directly related to the staggering increase of 244% of nongraphic injuries.
- Because physicians have no control over this 244% increase in claimants reporting injuries.
- Because the focus for changes in 1996 needs to be on the nonmedical cost: administrative cost and indemnity cost.



Robert G. Cox

Reflections on 35 Eventful Years as KMA's Leader

Robert G. Cox launched his career with the Kentucky Medical Association in 1961 and quickly proved his leadership abilities. Just seven years after he began with the Association (one of which was spent serving his country in the military), he was elevated to CEO, thus becoming the youngest CEO of a state medical association. This distinction has culminated in the eminent position he currently holds — the longest serving CEO in the nation. He has earned the respect of his colleagues and staff and has led his organization to national prominence.

A few of Bob Cox's major achievements for the Association are best encapsulated in the following comparisons:

— On June 30, 1968, just two months after Cox became CEO, KMA had a total reserve fund of \$45,066. On June 30, 1996, that reserve fund had climbed to \$3,955,233. On June 30, 1968, KMA's total assets were \$444,620. Today's assets are \$7,342,686. KMA's total annual income in Cox's 28 years as CEO has

jumped from \$197,000 to \$3,050,078.

— Even though KMA's membership has doubled under Cox's leadership, KMA staff remains the same in 1996 as 20 years ago. That's unbelievable when you consider how much medicine and association activities have changed in the last 20 years. But, while he has demanded much from his staff, he never expected them to give more than he himself was willing to give.

— When Cox became CEO, the KMA legislative effort consisted primarily of opposing an occasional chiropractor bill, and making sure the General Assembly funded the Rural Scholarship Fund. CME was just beginning to take hold — and physicians had few, if any, real public relation problems. In fact, the biggest controversy was over Blue Cross/Blue Shield's UCR program, and Medicare and Medicaid's three payment areas.

— Perhaps Cox's greatest legacy is the public image of the Kentucky Medical Association. This Association enjoys enormous prestige — is highly respected — and routinely rated by

legislators, bureaucrats, and the business community as one of Kentucky's top three in terms of political power and prestige on the statewide scene.

Former President Danny M. Clark, MD, noted at Cox's retirement banquet that "Bob Cox has an uncanny ability and talent to use gentle persuasion when working with the leadership and Board of Trustees to assure that decisions made are in the best interest of our patients — that they preserve the reputation and image of this Association and serve to enhance the medical profession.

Thousands of physicians owe a deep and lasting gratitude to this gentleman. To many of us gathered here tonight, the friendship he has provided transcends all of his business acumen and accomplishments."

The *Journal of the Kentucky Medical Association* is reflecting on how Bob Cox's leadership has shaped the KMA and what he foresees as the future of its nearly 6,000 member physicians, its staff, and his successor.

JKMA: *You've been with KMA for 35 years and at the helm of the Association for 29 years. What were the major medical issues when you first arrived on the scene at KMA in 1961?*

RGC: While there has been tremendous change in those 35 years, the major issues then are major issues today. We had concerns then about the health care delivery system, as we do today, and we were engaged in an aggressive, no holds barred fight against "socialized" medicine in the form of the King-Anderson Bill. Few people know that the intrusion of government into medicine was a part of the inaugural address of the first KMA President, W. L. Sutton, MD, in 1851, so that issue has been around a while. . . . and still is.

1961 was pre-Medicare and Medicaid days and we supported the Kerr-Mills Bill which passed. That program was designed for indigent medical care in all of the states.

Organizationally, KMA had just restructured into a system of committees serving under councils of specific program activities; started some new and active committees like the Highway Safety Committee, chaired by a pioneer in this field and a longtime friend who we recently lost to cancer, Art Keeney, MD; became a three delegate state to the AMA (we're now five); and pushed hard in the field of ethics and medical discipline. In January 1962, we moved into our newly erected Headquarters Office. Interestingly, we just moved again into a new office last month which offers more space and better facilities to serve Kentucky physicians.

JKMA: *This could be a lengthy list, but briefly, what have been some of the major changes in the health care field since you came to KMA?*

RGC: The greatest challenge here is to be brief. There's no doubt that the introduction of Medicare and Medicaid was the most monumental and historical change in health care this country has ever seen. It remains as one of the most profound events that has impacted our social and medical care system. Secondly, the tremendous advances in technology that have increased the length and

soon become a chronic condition.

Breakthroughs in technology and advancement in patient care, however, has increased health care costs. These increased medical costs have played a role in other major innovations such as movement from hospital inpatient care to less expensive outpatient care. For that same reason, we are witnessing a massive rush to managed care. The



Box Cox confers with two KMA executives — Bill Applegate, recently named KMA's Executive Vice President Designate (R), and Don Chasteen, Director of Public Affairs and KMA's chief lobbyist.

quality of life — and reduced the pain and suffering — is difficult to comprehend. Technology has exceeded and brought to reality preventions and cures we never dreamed would occur. Medicine's innovations and technology to keep people well, save and improve the quality of life, and make our population more productive are the landmarks of our country's success. Who would have believed, as one article recently noted, that AIDS may

growth of managed care will continue, but as the public becomes more knowledgeable, I predict the shift to managed care will slow dramatically, and to a great extent managing patient care will return to the physician.

Since 1965, politics has played a tremendous role in health care. Every session of Congress and the Kentucky General Assembly requires a major effort around KMA. The change in the balance of power in Frankfort from

administrative (the Governor's office) to the legislative has brought about significant changes in how we plan and carry out our legislative program.

JKMA: *What do you see as the most significant difference in medical associations today as compared to, lets say, 15 years ago?*

RGC: Today the medical association must prove its value — much more so than in the past. In the "good ole days," physicians belonged to organized medicine because it was expected. The medical community always presented a unified public front and backbiting or sniping within the profession was considered, as they said in the old days, "unseemly." Since their peers belonged to organized medicine, most all physicians felt they had to belong if they were going to be acceptable to the medical community; peer relationships and continuing education were enhanced; the public expected it, etc. Today, providing tangible benefits is a must. Much more needs to be done in the socioeconomic arena and we are certainly doing that. KMA is in the process of establishing a statewide PPO so that member physicians can maintain some sense of control of their practice. Another current event is KMA's lawsuit against the state over Medicaid which has been recently settled. As a result, Kentucky physicians will receive \$52,000,000 in retrospective reimbursement and another \$52,000,000 in increased payments over the 1996-98 biennium. That's \$104,000,000 and that should pay a lot of annual KMA dues. Today's issues are far more complex than 15 years ago which requires a more concentrated and sophisticated management approach to successfully handle them. Additionally, the Legislature is now a year-around effort rather than the traditional 60 days every two years. That is a big difference.

JKMA: *What do you see as KMA's number one priority in today's environment?*

RGC: Keeping control of patient care in physicians' hands. Traditionally, physicians and government have dominated the control of patient care. Control of patient care is being wrested from physicians by managed care organizations, major insurers, government, and in many cases, business itself. We remain committed to use the full power and resources of KMA to return patient care back into the individual physician's domain . . . and keep it there.



JKMA: *What has been the most enjoyable aspect of your leadership of KMA?*

RGC: An easy answer . . . people. Primarily the staff and physicians. I've spent 35 years around the finest people one could imagine . . . the KMA staff. They have been employees, partners, and business associates . . . but most of all my friends. They have always had a major effect on me 24 hours a day . . . not just 8 hours a day. Physicians are the other part of that equation. For 35 years my life has evolved around

physicians . . . day and night . . . seven days a week. Consequently, it was only natural that physicians became and remain close and special friends to Kay and me. We look forward to continuing to share those friendships within staff and among our physician friends in retirement.

JKMA: *During the years you've been at the helm of KMA, what do you feel has been the Association's biggest accomplishment?*

RGC: Two major accomplishments come to mind. I don't believe physicians understand the impact KMA has on their daily lives; how their offices operate; the manner in which they care for their patients; who, what and how they are reimbursed; and just the general freedoms they enjoy. Actually our biggest accomplishment is doing what leadership and staff do day in-day out to maintain the freedoms to practice medicine. We do something everyday to have a positive effect on them. The \$52 million settlement of our lawsuit, repeal of the provider tax, and the \$52 million biennial increase in Medicaid reimbursement is a classic example of KMA's work. However, similar events occur every session. Physicians see things happen but they rarely recognize the source. We're in Frankfort on a daily basis. We can be spotted in almost every arena — public or private — when physicians or their patients are affected.

If one pointed to a specific accomplishment, it was the establishment of The Kentucky Medical Insurance Company in 1978. Prior to KMIC, physicians were subject to the whims of two or three insurers and we dealt with a crisis every eight or ten years. KMIC stabilized that market overnight and it was organized by KMA to be owned and operated by physicians . . . existing solely for them. We committed to being there in times of need while others closed their doors or priced themselves out

of the market. KMIC is financially stronger today than ever before and continues to be a protector of all our membership whether they purchase their insurance through KMIC or their competitors.

JKMA: What are other accomplishments you have been particularly proud of during the years?

RGC: The KMA Annual Meeting would have to be one. We have a registration of about two and a half thousand at our Annual Meeting. No state association comes anywhere near registering the percentage of membership comparable to KMA. We run a strong scientific program, specialty group sessions, large exhibit hall, and incorporate the business meetings via the House of Delegates. Doctors traditionally attended because it was the thing to do and to visit annually with their friends and classmates. Today we have to convince them that their time would be well spent at the meeting, and so far we have succeeded. We have also established a number of subsidiary and KMA family-type organizations that have and are providing needed benefits to members. Whether we're talking about KEMPAC, an insurance agency, a changing Rural Kentucky Medical Scholarship fund, Impaired Physician Foundation, or any number of other "corporate entities," we will never stop trying to find and fill the needs of our members.

It is also important to mention the results of the 1996 Kentucky Legislature. We put forth our best effort in history in this year's session; physicians responded statewide and without mentioning all of our accomplishments, our results almost exactly matched our goals.

JKMA: You have a national reputation for leadership and selecting good staff. What is your secret — what do you

look for when hiring people to work for Kentucky physicians?

RGC: I'm not nearly as interested in degrees or educational backgrounds as I am the person. After talking to someone for a brief time, I feel I have the instinct to know what that person is made of. If we can hire ethical individuals with good work habits and the desire to succeed, we can mold them into an excellent staff member and producer. At KMA we are family and everyone we hire must fit into that family role. Degrees or diplomas are secondary to fitting the mold developed for association work and especially to serve our membership. I'm proud to be leaving a staff here that has nearly 300 years of KMA experience. I'll miss them, but they don't need me anymore.

JKMA: What have been your biggest disappointments during your years at KMA?

RGC: Most disappointments have revolved around the legislature. Governor Brereton Jones and his administration provided the greatest disappointment and embarrassment. We worked extremely close with him eight years and sincerely believed we could do so much with him in the health care arena for the people of Kentucky during his term as Governor. However, he seemed to surround himself with anti-physician staff, cut us off from communication, ignored our recommendations, and took the entire state downhill healthwise. Unfortunately the opportunity for progress could never have been better. The 1996 Session removed most of his so-called reforms, and I suspect by the time the 1998 Session is over the remainder will be gone. That was "the" disappointment organizationally, and personally for many physicians who sacrificed politically within the Association along with staff. He was a bitter disappointment.



JKMA: Where would you like to see improvements within KMA, and if you could change anything what would it be?

RGC: Communication. Every Kentucky physician should be a member of KMA and through unification, we could reach most goals. If every physician truly knew what KMA was doing for them, we would have 100% membership. As progressive as we are today, we still don't have the ability to get physicians to hear or read . . . it remains difficult to keep them informed. I always said, if I could put all KMA does in a syringe and vaccinate every doctor, we would have the strongest team in the world. We haven't achieved the communication dream — but we keep trying.

JKMA: What do you see as the greatest challenge facing KMA during the next few years?

RGC: To answer that question we have to go back to our earlier discussion about the health care delivery system, especially managed care. We must find a way to balance relationships between insurance companies, physicians, and patients in managed care settings. Our responsibility is to advocate for and protect patients and patients' freedom of choice while maintaining the prerogatives of physicians to determine and provide the best patient care possible. Physicians must not waiver from their role as the patient's advocate to maintain and strengthen physician-patient relationships. It's KMA's responsibility to help physicians. The provision of quality medical care is not for sale. To do less would be suicide for the profession.

JKMA: Would you like to reflect on friendships you have made over the years?

RGC: Staff, physicians, my peers across the country, business associates, and representatives of allied health organizations are all an integral part of our circle of friends. My acquaintances are in the thousands — my friends in the hundreds — so I had better not start naming names. Besides, we would need a special issue of the *Journal* to fully answer that question.

JKMA: What is your advice to your successor, Bill Applegate?

RGC: Be patient. Look at the big picture — try to absorb what the question is about — and make a decision based on the facts. Don't act hastily when dealing with any problem . . . especially a crisis . . . and never act hastily when dealing with people. Have a thick skin for the few who want to cut on you and a ready smile for those who really know and compliment you. Do what's right no matter what, and remember the good

guys always win in the end. Finally, don't lose your sense of humor. Life would be unbearable without a funny story — especially one on yourself. Bill and I have worked together for 28 years and I'm not worried about him. Besides, he has his wife Suzie to lean on when he needs to.

JKMA: What are your retirement plans?

RGC: I really don't know at this point. I'll just take it a day at a time. A physician friend said the other day, "Bobby, you have so much knowledge about the health care field, why don't you become a consultant?" My answer was if I wanted to do that I wouldn't have retired because that's what I have done for 35 years. I've heard that when you retire you wake up with nothing to do all day and by noon you have it half done. I might try that.

In the immediate future, Kay and I plan to spend January through March in Naples, Florida (to keep retirement shock from effecting me too soon). Then we will visit with our children in Texas and North Carolina, and maybe we'll do some traveling. We both love golf so we'll do a lot of that wherever we are. In my younger days I did some oil painting which I'll probably get back to, and I may even try to write a book or two if boredom sets in. I always wanted time to write and read more. I've gone home all my career with a briefcase full of medical papers, so who knows, some fiction books may end up in the old retirement briefcase. Of course, fishing will play a vital role. But overall, we expect to spend lots of time with friends. We'll be watching the progress of KMA of course and rocking and reminiscing about a great career of 35 years and all of the wonderful experiences we had.

Sue Tharp
Managing Editor

Robert G. Cox

A Personal Profile

A native Kentuckian, Bob Cox was born in Owensboro and graduated from high school there. Following graduation from Western Kentucky University in 1955, he returned to Owensboro to work at General Electric where his father had worked from age 18 until retirement. Still single, and active in the Owensboro Jaycees, Bob was encouraged by (now Senator) Wendell Ford, the outgoing US Jaycee President, to apply for the vacant Executive Vice President position of the Kentucky Jaycees, headquartered in Louisville. Subsequently, he was named to that office for a three-year term and moved to Louisville in June of 1958.

In November of that year, Bob married Kay Omer, also an Owensboro native, and they continued the Jaycee life, his first introduction to association work. Some of the state Jaycee leadership were in the health field and knew that the Kentucky Medical Association was looking for a young executive. Since they knew Cox's predecessor at KMA, Mr Joe Sanford, they "sold" Sanford on Cox before he ever had an interview.

Hired at KMA on a Wednesday in July of 1961, Cox heard on the radio the following Friday that his reserve Division (the 100th) had been recalled to active duty (it was during the Berlin crisis). Having served on active duty after being commissioned following college graduation, Cox suddenly was being activated just as a new career was about to begin. After one year, his duty completed, he resigned from the Reserves and returned to KMA in August 1962. Cox noted, "It was a great career decision and I have been with KMA. . . . happily. . . . ever since."

Along the way, Cox has served as president of the Professional Convention Management Association (PCMA) and American Association of Medical Society Executives (AAMSE), the two most prestigious organizations in the medical executive profession.

Bob Cox is dedicated to the well-being of his family. He and Kay, in his words, "grow prouder of our two children each day." Barbara Ann, their daughter, has her own real estate career in Dallas, Texas, where she and her husband, Jim Jones, live. "It's scary when I'm reminded she is 33 years old," says Cox. John, the "baby" of the family, is 29. He and his wife, Kim, live in Greensboro, North Carolina, where he is working his way through the corporate ladder. They have no grandchildren yet, but when they do, I'm sure Bob will need a lot of print space to talk about them.

Joining Bob at a KMA banquet honoring his 35-year tenure were family members, L to R, son John and his wife Kim, Bob's mother Thelma, wife Kay, daughter Barbara and her husband Jim Jones.



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Pulmonary Coccidioidomycosis in Kentucky

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Preparation of this manuscript was begun in October 1994 prior to the death of Marcus L. Dillon, MD, in December 1994. This article is dedicated to his memory.

Coccidioidomycosis is a highly infectious disease caused by the dimorphic fungus, Coccidioides immitis that is endemic to the arid and semi-arid regions of the southwestern United States, Mexico, Central America, and South America. The majority of infections from C immitis are asymptomatic; however, approximately 40% of infected individuals present with symptoms ranging from a mild flu-like respiratory infection to acute pneumonia that may lead to chronic progressive pulmonary infection or occasionally disseminated disease. Due to the mobility of the population, increasing numbers of cases are being recognized outside endemic areas. We report five patients with coccidioidomycosis diagnosed at the University of Kentucky Medical Center during the period from 1984 to 1993 in order to illustrate the clinical and radiographic spectrum of findings that may be encountered with the disease. In a patient with unexplained pulmonary symptoms, a history of recent travel to or immigration from an endemic area may be an early clue to the diagnosis of coccidioidomycosis.

Coccidioidomycosis is a deep mycosis that usually begins as a respiratory infection.¹ The causative organism is *Coccidioides immitis*, a dimorphic fungus that grows in soil and in culture as mycelia with septate hyphae that reproduce by the formation of multiple 2-5 µm arthrospores that are highly infectious and easily airborne.¹⁻⁴ In tissue *C immitis* grows as thin-walled spherules measuring 10-80 µm in diameter that reproduce by the formation of multiple 2-5 µm endospores.¹⁻⁴ When the spherules rupture, endospores are released in tissue and grow into spherules that form their own endospores, thus continuing the cycle in the host indefinitely.¹⁻⁴

C immitis grows best in alkaline soil free from severe frost where a dry season follows a wet one.² *C immitis* is endemic to the arid and semi-

arid regions of the southwestern United States, northern Mexico, and parts of Central and South America including Guatemala, Honduras, Colombia, Venezuela, Paraguay, and northern Argentina.^{1,2,4} In the United States the endemic area includes California, central and southern Arizona, southern New Mexico, western Texas, southwestern Utah, and the southern tip of Nevada.^{1,2,4,5} In California, the San Joaquin Valley is the area most involved; however, cases have been reported from north of San Francisco to the Mexican border.^{1,2,4}

Although most cases of coccidioidomycosis occur in endemic areas, increasing numbers of cases are being recognized outside the endemic areas.^{4,7} This is thought to be due to constant turnover of military troops in desert training centers, increased immigration from endemic areas, and rapidly increasing recreational travel to endemic areas.^{2,4,7} Because of these phenomena, physicians outside the endemic areas should be aware of the clinical and radiographic manifestations of coccidioidomycosis.⁶ We report five patients with pulmonary coccidioidomycosis diagnosed at the University of Kentucky Medical Center during the 10 year period from 1984 to 1993 in order to illustrate the clinical and radiographic features of the disease, and to help physicians in Kentucky be more aware of the fact that the disease may occasionally be encountered here.

Case Reports

Case 1 — The patient is a 50-year-old white male from Phoenix, Arizona. In 1983 he was diagnosed as having *Mycobacterium avium* pulmonary disease. His chest radiograph at that time showed two irregular pulmonary nodules in the left upper lobe and sputum cultures were positive for *M avium*. Sputum cultures and serologic tests for *C immitis* were negative at that time. He was treated with a 5-drug antimycobacterial chemotherapeutic regimen for 8 months.

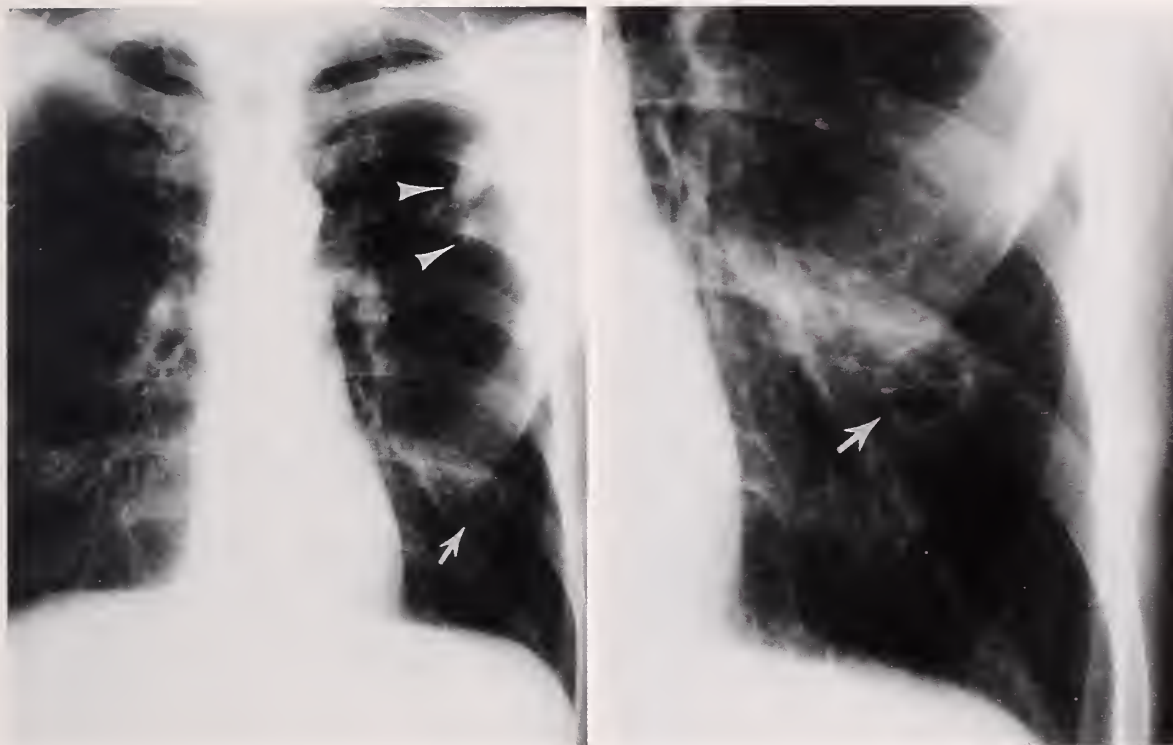


Fig 1 — (A) Chest radiograph of 50-year-old man with combined *Mycobacterium avium* and *Coccidioides immitis* disease shows 2 left upper lobe pulmonary nodules from *M avium* (arrowheads) and a thin-walled cavity in the left lower lobe from *C immitis* (arrow). Surgically confirmed. (B) Close-up of thin-walled cavity in left lower lobe from *C. immitis* (arrow).

In 1984 he moved to Lexington, Kentucky. He presented to the hospital in June 1984 with a history of weight loss, anorexia, hemoptysis, cough productive of purulent sputum, and chest pain of several months duration. He was an 80 pack-year smoker. A chest radiograph obtained at that time showed no change in the two left upper lobe nodules; however, a new thin-walled cavity was present in the left lower lobe (Fig 1). It was initially thought that the new cavity represented progression of *M avium* disease. He was begun on a 6-drug antimycobacterial regimen consisting of streptomycin, rifampin, ethambutol, pyrazinamide, pyridoxine, and isoniazid. Over the next several months the left upper lobe nodules got slightly smaller but the left lower lobe cavity remained unchanged and the patient's symptoms persisted. In November 1984 he was taken to the operating room and the left lung lesions were resected. Histologic examination and culture of the upper lobe nodules revealed *M avium*. Examination of the left lower lobe cavity revealed numerous intact and fragmented spher-

ules of *C immitis* containing numerous endospores. The patient did well postoperatively and did not experience reactivation of his disease.

Case 2 — The patient is a 44-year-old homeless black male who moved from San Diego, California to Lexington, Kentucky in early September 1993. He was HIV-positive and had a CD4 count of 11. He presented to the hospital on September 22, 1993, with a 2-week history of a mild flu-like illness and fever, chills, and cough productive of yellow-white sputum for 3 days. On admission his temperature was 102° F. There was increased tactile fremitus posteriorly over the right mid lung field and rales were present in the right lung base. His WBC was 2300.

The admission chest radiograph (Fig 2) showed a mixed interstitial and alveolar infiltrate involving the right middle and lower lobes associated with right hilar and right paratracheal lymphadenopathy. Because of the lymphadenopathy it was thought that he had either tuberculosis or a fungal infection. He was placed in respiratory isolation and treated empirically with trimetho-

Pulmonary Coccidioidomycosis



Fig 2 — Chest radiograph of 44-year-old HIV-positive man with acute primary pulmonary coccidioidomycosis shows a mixed interstitial and alveolar infiltrate in the right middle and lower lobes associated with right hilar and right paratracheal lymphadenopathy (arrows).



Fig 3 — Disseminated coccidioidomycosis in a 33-year-old woman on steroids. The chest radiograph demonstrates a diffuse reticulonodular pattern throughout both lungs.

prim and sulfamethoxazole, cefotaxime, fluconazole, isoniazid, rifampin, ethambutol, and metronidazole. He refused lumbar puncture. The PPD skin test was negative and sputum AFB and fungal smears were negative. Five days after admission, sputum cultures were positive for *C immitis*. The empirical treatment was discontinued and he was removed from respiratory isolation; he was initially treated with 71 mg of amphotericin B and was then switched to 400 mg fluconazole orally per day. The patient symptomatically improved in the hospital and was discharged 10 days after admission on 400 mg fluconazole per day for 3 months plus rifabutin, trimethoprim and sulfamethoxazole, and zidovudine. He did well from the standpoint of coccidioidomycosis without recurrence of the disease.

Case 3 — The patient is a 33-year-old female who moved from Arizona to Ashland, Kentucky in the Spring of 1993. While living in Arizona she developed systemic lupus erythematosus with pleural effusion which was ANA-positive; she was started on high-dose steroids and initially did well. She presented to the hospital in June 1993 with a several week history of productive cough and a skin ulcer on her left leg. She was afebrile. Physical examination revealed coarse breath sounds with rhonchi and mild expiratory wheezes bilaterally, and a 1 cm ulcerating skin lesion on the posterior aspect of her left leg.

The admission chest radiograph (Fig 3) showed a diffuse reticulonodular pattern throughout both lungs. Her WBC was 5900. The PPD skin test was negative, and sputum AFB smears and cultures were negative. Sputum wet-preparation showed numerous spherules of *C immitis* and serum complement-fixing antibody titers for *C immitis* were 1:32 indicating disseminated disease. Sputum cultures subsequently grew *C immitis*. Pulmonary function tests showed no evidence of airflow obstruction and moderately severe restriction with FVC of 1.36 L (36% predicted), FEV₁ of 1.10 L (34% predicted), FEV₁/FVC ratio of 0.81 (95% predicted), and TLC of 2.58 L (50% predicted). Biopsy of the skin ulcer was negative. She was treated with amphotericin B 40 mg intravenously every other day to a total of 2.5 g. She did well from the standpoint of coccidioidomycosis with resolution of her pulmonary symptoms and healing of the skin ulcer with no recurrence of her disease. She is still being followed and treated for systemic lupus erythematosus.

Case 4 — The patient is a 79-year-old Hispanic

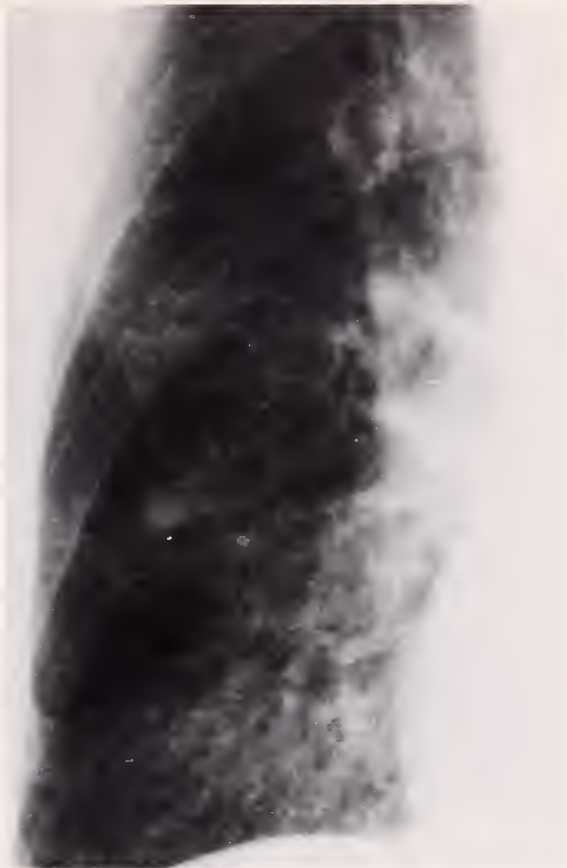


Fig 4 — (A) Chest radiograph of a 79-year-old Hispanic man with disseminated coccidioidomycosis shows a diffuse miliary nodular pattern throughout both lungs. (B) Close-up of right lung better shows the diffuse miliary nodular pattern.

male who moved from Mexico to Danville, Kentucky in May 1984 to live with relatives. Shortly after arriving in Danville he developed fever, persistent nonproductive cough, and ulcerating skin lesions on his forehead and lips. His physical examination was normal; his lungs were clear to percussion and auscultation. The chest radiograph (Fig 4) showed a diffuse miliary nodular pattern throughout both lungs. He subsequently underwent bronchoscopy; cytology and AFB and fungal smears and cultures from multiple bronchial brushings and washings were negative. Culture of material obtained from biopsy of an ulcerating skin lesion on his forehead grew *C immitis*. He was then treated with amphotericin B to a total dose of 2.5 g and did well with no recurrence of his disease.

Case 5 — The patient is a 70-year-old white man from Las Vegas, Nevada who made occasional trips to Lexington, Kentucky to visit friends. In July 1986 he presented to the outpatient clinic for a routine yearly physical examination. He had a myocardial infarction in 1979, but currently had no angina or other cardiac or pulmonary symptoms. His physical examination was normal. A chest radiograph obtained as part of the routine physical examination (Fig 5A) showed a 1 cm nodule in the right upper lobe that was not present in 1979. He was a nonsmoker. He walked and

jogged in the desert around Las Vegas 3-4 times per week; although he had occasional "chest colds" he remembered no specific episode of pneumonia. Linear tomography of the nodule (Fig 5B) showed central calcification within the nodule indicating that it was benign. Because of the benign appearance of the nodule and the history of exposure in an endemic area, it was felt that the nodule was most consistent with a coccidioidal granuloma.

Discussion

Over 99% of cases of coccidioidomycosis result from the inhalation of arthrospores of *Coccidioides immitis*.^{2,4} Rarely, the disease may follow direct inoculation of the organism in tissue.^{1,4} Infections with *C. immitis* are most common in the summer, but may occur at any time of the year following dry and windy conditions.^{1,2,8} Infections may also follow earth moving or dusty conditions related to agriculture, construction, military maneuvers, or archaeological digs.^{2,4,6} However, infection may occur from only a casual automobile drive through an endemic area.⁶ Laboratory workers are also at risk if exposed to the fungus growing on culture medium.^{1,2} Occasionally the organism may be transmitted by contaminated soil, food, textiles, or artifacts transported from an endemic area.^{1,4} The organism infects humans, do-

Pulmonary Coccidioidomycosis



Fig 5 — (A) Coccidioidoma in 70-year-old man from Las Vegas, Nevada. The chest radiograph shows a pulmonary nodule in the right upper lobe (arrow) that was not present on earlier chest radiographs. (B) Linear tomography of the nodule demonstrates central calcification within the nodule (arrowheads) indicating its benign nature.

mestic animals, and wild rodents; however, neither animal-to-animal nor animal-to-human transmission has been documented.^{1,2} Human-to-human transmission occurs rarely from exposure to contaminated sputum or dressings.^{1,2}

The incidence of infection is very high in endemic areas.^{2,4} Approximately 3 to 5% of the population of endemic areas are infected with *C immitis* each year;^{2,4,7,9} the prevalence of positive skin tests to coccidioidin or spherulin, indicating prior infection, may be as high as 80% in some areas.⁹ Up to 25% of new immigrants to an endemic area may be skin test positive after 1 year and 50% may be skin test positive after 4 years.² It has been estimated that there are 100,000 new cases of coccidioidomycosis in the United States each year and that 70 of these individuals die.^{2,10} The majority of cases occur in the desert Southwest; however, due to an incubation period of 7-28 days, and the fact that long-quiescent disease acquired years earlier in endemic areas may become reactivated, cases of coccidioidomycosis may be seen far from the endemic area.^{1,4,11}

Most cases of coccidioidomycosis are asymptomatic and resolve spontaneously; however, even such cases usually provide a lasting immunity.^{4,10} Approximately 30% to 40% of cases are symptomatic.^{2,4,7,9,11} Coccidioidomycosis in symptomatic patients may be divided into acute primary pulmonary disease, chronic or persistent primary pulmonary disease, and disseminated disease.⁹

Acute primary pulmonary coccidioidomycosis, also known as "valley fever," accounts for approximately 95% of clinically recognized cases.^{4,9,10} Primary disease may affect persons of either gender or of any age.⁴ The most common symptoms include fever, cough, chest pain, malaise, headache, backache, night sweats, and anorexia.^{2,4,9,10} About 20% of clinically recognized cases develop allergic, hypersensitivity reactions including erythema nodosum, erythema multiforme, and arthralgia.^{1,4,9,10} This is most common in white women and is least common in black and Filipino men.^{1,4,10} Disseminated disease is unlikely in a patient who develops a rash.⁹

Pathologically, the initial pulmonary cellular reaction to *C immitis* is that of an acute suppurative bronchitis and bronchopneumonia.^{4,10} After about a week there is granuloma formation with central coagulative necrosis surrounded by histiocytes, lymphocytes, and giant cells that contain the fungus.^{4,10} Chest radiographs of patients with acute primary disease may be normal,¹⁰ but in 75% to 80% of cases they show one or more areas of patchy interstitial or alveolar infiltration (Fig 2).^{2,4,5,10,12,13} Occasionally dense segmental or lobar consolidation may occur,^{4,5,12,13} and thin-walled or thick-walled cavitation may develop.^{4,6,12} Approximately 20% of cases are associated with hilar or mediastinal lymphadenopathy (Fig 2).^{2,4,9,10,12,13} Although most patients with hilar or mediastinal lymphadenopathy do not develop

disseminated disease, patients with lymphadenopathy are at greater risk for dissemination than those without it.^{4,9} Pleural effusion may also be present in about 20% of cases.^{2,4,12,13} Pleural effusion usually results from direct spread of parenchymal disease into the pleural space, or from hypersensitivity reaction, rather than from hematogenous dissemination.^{9,14} Rarely, acute coccidioidomycosis may also involve the tracheobronchial tree with tracheobronchial ulceration, granuloma formation, and glottic and subglottic masses that may cause upper airway obstruction and stridor.^{5,7}

In most cases, acute primary pulmonary coccidioidomycosis is mild and self-limited and runs a course of 3-6 weeks, after which the patient completely recovers.⁴ Primary disease that lasts more than 6 weeks is referred to as persistent or chronic primary pulmonary coccidioidomycosis^{2,4,9,10} and occurs in roughly 5% of cases.⁴ Persistent primary coccidioidomycosis may run a chronic course lasting months or years.¹⁰ Only 25% of patients with persistent disease have a history of prior acute illness.⁴ The remaining patients have minimal or no symptoms and their pulmonary abnormalities are discovered incidentally on chest radiographs done for other reasons.^{4,9}

Chronic pulmonary cavitation is the most common abnormality in persistent coccidioidomycosis.⁹ There may be thin-walled "grape skin" cavities or thick-walled "donut" cavities which may be solitary or multiple; most often the cavities are thin-walled and solitary (Fig 1).^{2,4,5,9,10,12,13} These cavities may persist relatively unchanged for long periods of time; however, approximately 50% of the cavities close spontaneously.¹⁰ Bacterial superinfection of the cavity may result in rapid enlargement and deflation of the cavity, a pattern that is highly suggestive of coccidioidomycosis rather than other forms of granulomatous infection.^{2,4,9,13} Occasionally the cavities may erode through the pleural surface producing either spontaneous pneumothorax or bronchopleural fistula with empyema formation.^{2,4,9,11-13} Rarely, a fungus ball or mycetoma from either *C immitis* or *Aspergillus* may be seen within one of these cavities.^{2,4,9,13,15}

Pulmonary nodules (coccidioidomas) are also a common manifestation of persistent pulmonary coccidioidomycosis.^{2,4,5,12,13} Coccidioidomas may range in size from 0.5 to 6 cm; they are usually solitary (Fig 5) but may be multiple.^{2,4,5,12,13} They are more common in the mid

and upper lung zones and may involve the anterior segments.² Histologically, coccidioidomas reflect chronic caseating granulomatous inflammation and consist of a central zone of necrosis surrounded by a fibrous capsule and chronic inflammatory infiltrate.^{2,4,10} On computed tomography, coccidioidomas may show marked contrast enhancement and may have a central low-density zone representing central necrosis.^{2,4} Occasionally a coccidioidoma will discharge its contents into a bronchus leaving behind a thin-walled or thick-walled cavity.⁵ Coccidioidomas may be discovered incidentally making distinction from pulmonary neoplasm difficult.^{2,4} Needle biopsy of these nodules shows characteristic spherules of *C immitis* in about 50% of cases.¹⁶ Although healing of coccidioidomas with calcification occurs less frequently than with histoplasmosis, calcification does occur in many coccidioidomas, and its presence helps to indicate the benign nature of the nodule (Fig 5).^{2,4,5,13,17} Although most coccidioidomas follow a benign course, breakdown with reactivation of disease or even hematogenous dissemination may occur, especially if the patient becomes immunocompromised.^{4,13}

The remaining patients with persistent or chronic pulmonary coccidioidomycosis show one or more areas of pneumonia that may persist for months.⁴ These persistent areas of pneumonia may be associated with hilar or mediastinal lymphadenopathy or pleural effusion.⁴ Approximately 1% of patients with coccidioidomycosis develop chronic suppurative cavitory disease.^{2,4,9,10} These patients often have symptoms of fever, cough, sputum production, dyspnea, night sweats, and hemoptysis.^{2,9} The symptoms may be indolent and present for years.² Chest radiographs often show bilateral apical fibronodular lesions, multiple upper lobe cavities, pulmonary fibrosis with upward hilar retraction, bronchiectasis, and fibrous pleuritis.^{2,4,10,12,13} The changes closely resemble those of chronic cavitory pulmonary tuberculosis^{2,4,9,10}; in fact, in some cases tuberculosis and coccidioidomycosis coexist (Fig 1).²

Hematogenous dissemination of *C immitis* occurs in 0.5% to 1% of cases.^{4,10} Dissemination is more common in blacks, Filipinos, Hispanics, and American Indians; neonates and very young infants; elderly men; pregnant women; diabetics; and patients who are immunocompromised including those on steroids and other immunosuppressive drugs, renal dialysis and transplant patients, those with lymphocytopenia, and patients who are HIV-positive or who have AIDS.^{2,4,9,10,12,13,18-20}

Pulmonary Coccidioidomycosis

Radiographically hematogenous dissemination is heralded by the development of either a diffuse miliary nodular pattern (Fig 4) or a reticulonodular pattern (Fig 3) on the chest radiograph.^{2, 4, 5, 12, 13} Hematogenous dissemination occurs throughout the lungs and other sites throughout the body.⁴ The small nodular foci of pulmonary disease may show a granulomatous, pyogenic, or mixed inflammatory reaction.⁴ The tracheobronchial lymph nodes often show caseous or liquefaction necrosis, and in most cases it is thought that hematogenous dissemination develops from the necrotic tracheobronchial lymph nodes.^{4, 18} Dissemination may occur either within a few days of the onset of illness,^{4, 18} or it may occur after several weeks or months.⁹ Dissemination should be suspected clinically when the clinical and radiographic findings do not subside, fever persists, the titer of complement-fixing antibody rises to 1:16 to 1:32 or greater, and the sedimentation rate remains elevated.⁴ In some patients, particularly those who are immunocompromised, there may be no history of a preceding respiratory illness, suggesting that dissemination occurred from reactivation of a long-quiescent focus of disease.⁹

Disseminated coccidioidomycosis can involve any extrapulmonary site; however, the skin is the most commonly involved organ and is involved in most cases.^{2, 21} In fact, the skin may be the only extrapulmonary site involved,²¹ as in our cases 3 and 4. Skin lesions consist of verrucous granulomas, subcutaneous abscesses, and indolent ulcers.²¹ Verrucous lesions are more common on the face and nasolabial folds, abscesses are more common under the arm or on the back or hip, and ulcers are more common on the hands and lower extremities.²¹ Central nervous system involvement occurs in 30% to 70% of cases and is usually manifested as a chronic, granulomatous meningitis and ependymitis that encases the brain and causes obstructive hydrocephalus.^{2, 9, 13} Untreated, coccidioidal meningitis is almost always fatal.² Cerebral coccidioidal granulomas, deep-gray and white matter disease, vasculitis, and spinal arachnoiditis may also occur.¹³ Bone involvement occurs in 10% to 50% of cases and is manifested as one or more areas of indolent osteomyelitis that may be associated with coccidioidal arthritis, overlying soft tissue abscesses, or draining sinuses.^{2, 9, 13} The spine, long bones, skull, and ribs are commonly involved.^{2, 9, 13} The genitourinary system is not uncommonly involved in disseminated coccidioidomycosis.⁹

Usually only the kidneys are involved; however, the prostate, epididymis, uterus, and fallopian tubes may rarely be involved.¹³ Other sites of involvement include the liver, spleen, lymph nodes, adrenal glands, and larynx.^{2, 10, 13} Involvement of the pericardium is rare but is often associated with fatal cardiac tamponade or constrictive pericarditis despite early treatment.^{13, 22}

The diagnosis of coccidioidomycosis may be difficult. A positive skin test to coccidioidin or spherulin, in a patient with clinical evidence of the disease, is suggestive; however, a positive skin test can come from prior disease.²³ Furthermore, a negative skin test does not rule out the disease and is common in severe and disseminated disease.²³ Serum precipitins (IgM antibodies) often appear in the first few weeks of primary disease, but usually disappear after 8-12 weeks.^{2, 4, 9} Although they are not of prognostic significance, they do indicate that acute coccidioidomycosis is present.^{2, 4, 9} As the precipitins wane, complement-fixing IgG antibodies appear.^{2, 4, 9} Unfortunately, in mild disease, and even in some cases of severe disease, these antibodies may not develop or may be very low (<1:8).^{2, 4, 9} A high and rising titer of complement-fixing antibody ($\geq 1:16$) indicates disseminated disease and is a poor prognostic sign.^{2, 4, 9} The diagnosis may be confirmed by identifying characteristic spherules of *C immitis* or by a positive culture for *C immitis* from body tissues or fluids including tracheal aspirates, sputum, bronchial washings, urine, cerebrospinal fluid, blood, or bronchial brush, percutaneous needle, or skin biopsy specimens.^{4, 9, 11, 16, 18, 21} It is difficult to obtain a positive culture from cerebrospinal fluid; however, complement-fixing antibody is present in the cerebrospinal fluid in 95% of patients with meningeal involvement and is adequate evidence to initiate treatment.⁹ It is also important to remember that a history of recent travel to or immigration from an endemic area may be an important early clue to the diagnosis outside the endemic areas.

Most cases of acute primary pulmonary coccidioidomycosis are self-limited and require no treatment.^{1, 9, 24} Patients with acute primary disease should be treated, however, if the disease persists for more than 6 weeks, or if the patient has one or more known risk factors for developing disseminated disease including black, Filipino, Hispanic, or American Indian race; diabetes; pregnancy; steroid use; immunosuppressed state; and a high or rising serum complement-fixing antibody titer.^{9, 24} Patients with symptomatic chronic

disease and with disseminated disease should also be treated.^{4,9,24}

Amphotericin B remains as the "gold-standard" for the treatment of coccidioidomycosis.^{4,9,24} Amphotericin B should be given intravenously at a dose of 0.5 mg/kg/day for a total dose of 500 to 2500 mg.^{9,24} Patients with disseminated disease require a total dose of at least 2.5 g and may require up to 5 g in some cases.²⁴ In patients with meningeal disease amphotericin B should be administered intrathecally until the cerebrospinal fluid contains no complement-fixing antibody.⁹

The azoles, miconazole, ketoconazole, fluconazole, and itraconazole, are alternative drugs that may be used in some patients.^{2,24,25} The response is less than that with amphotericin B, and there are relapses in about one-third of cases, but the toxicity is considerably less.²⁵ Miconazole, 400-1200 mg intravenously every 8 hours, may be used in patients with coccidioidomycosis that is refractory to treatment with amphotericin B.²⁴ More recently, oral ketoconazole, fluconazole, and itraconazole have been used successfully to treat primary and nonmeningeal disseminated coccidioidomycosis.^{4,24,25} Usual doses are 400 mg daily; the duration of therapy ranges from 3 months to several years.²⁵ There is also some evidence to suggest that fluconazole in doses of 800-1200 mg may be of some value in treating central nervous system disease.²⁵

Surgery has a limited role in the treatment of coccidioidomycosis. Pulmonary nodules or cavities from coccidioidomycosis may be resected for diagnostic purposes.^{4,9} Furthermore, surgery is generally considered to be indicated for the resection of large (>5 cm), rapidly enlarging, or persistent subpleural cavities; superinfected cavities; and cavities associated with life-threatening hemoptysis.^{4,9,24} Perioperative amphotericin B, 500 mg intravenously, is recommended but there is still a 10% incidence of coccidioid bronchopleural fistula formation with empyema postoperatively, and a 10% to 20% incidence of recurrent cavities postoperatively.^{9,24}

References

- Benenson AS: *Control of Communicable Diseases in Man*. 11th ed. American Public Health Association, Washington, DC; 1970:58-60.
- Fraser RG, Paré JAP, Paré PD, Fraser RS, Genereux GP. *Diagnosis of Diseases of the Chest*, vol 2. 3rd ed. Philadelphia: Saunders; 1989:957-968.
- Kobayashi GS. Fungi. In: Davis BD, Dulbecco R, Eisen HN, Ginsberg HS, Wood WB Jr, eds. *Microbiology Including Immunology and Molecular Genetics*. 2nd ed. Hagerstown: Harper and Row; 1973:991-994.
- Batra P. Pulmonary coccidioidomycosis. *J Thorac Imaging*. 1992;7(4):29-38.
- Birsner JW. The roentgen aspects of five hundred cases of pulmonary coccidioidomycosis. *AJR*. 1954;72:556-573.
- Klein EW, Griffin JP. Coccidioidomycosis (diagnosis outside the Sonoran zone): the roentgen features of acute multiple pulmonary cavities. *AJR*. 1965;94:653-659.
- Moskowitz PS, Sue JY, Gooding CA. Tracheal coccidioidomycosis causing upper airway obstruction in children. *AJR*. 1982;139:596-600.
- Flynn NM, Hoepfich PD, Kawachi MM, et al. An unusual outbreak of windborne coccidioidomycosis. *N Engl J Med*. 1979;301:358-361.
- Boyers MC, Zwischenberger JB, Cox CS Jr. Clinical manifestations of pulmonary fungal infections. *J Thorac Imaging*. 1992;7(4):12-22.
- Haque AK. Pathology of common pulmonary fungal infections. *J Thorac Imaging*. 1992;7(4):1-11.
- Edelstein G, Levitt RG. Cavitory coccidioidomycosis presenting as a spontaneous pneumothorax. *AJR*. 1983;141:533-534.
- McAdams HP, Rosado-de-Christenson ML, Lesar M, Templeton PA, Moran CA. Thoracic mycoses from endemic fungi: radiologic-pathologic correlation. *RadioGraphics*. 1995;15:255-270.
- McGahan JP, Graves DS, Palmer PES, Stadalnik RC, Dublin AB. Classic and contemporary imaging of coccidioidomycosis. *AJR*. 1981;136:393-404.
- Lonky SA, Catanzaro A, Moser KM, Einstein H. Acute coccidioid pleural effusion. *Am Rev Respir Dis*. 1976;114:681-688.
- Belgrad R. Fungus ball — an unusual manifestation of coccidioidomycosis: a case report. *Radiology*. 1971;101:289-290.
- Forseth J, Rohwedder JJ, Levine BE, Saubolle MA. Experience with needle biopsy for coccidioid lung nodules. *Arch Intern Med*. 1986;146:319-320.
- Sargent EN, Balchum E, Freed AL, Jacobson G. Multiple pulmonary calcifications due to coccidioidomycosis. *AJR*. 1970;109:500-504.
- Child DD, Newell JD, Bjelland JC, Spark RP. Radiographic findings of pulmonary coccidioidomycosis in neonates and infants. *AJR*. 1985;145:261-263.
- Yoshino MT, Hillman BJ, Galgiani JN. Coccidioidomycosis in renal dialysis and transplant patients: radiologic findings in 30 patients. *AJR*. 1987;149:989-992.
- Stansell JD. Fungal disease in HIV-infected persons: cryptococcosis, histoplasmosis, and coccidioidomycosis. *J Thorac Imaging*. 1991;6(4):28-35.
- Jacobs SE, Whitlock WL, Dietrich RA. Pulmonary infiltrates, eosinophilia, and a facial skin nodule. *Chest*. 1990;97:476-478.
- Chowdhury JK, Habibzadeh MA. Disseminated coccidioidomycosis with pericarditis: successful treatment with amphotericin B. *Chest*. 1977;71:533-535.
- Sarosi GA, Catanzaro A, Daniel TM, Davies SF. Clinical usefulness of skin testing in histoplasmosis, coccidioidomycosis, and blastomycosis. *Am Rev Respir Dis*. 1988;138:1081-1082.
- Sarosi GA, Bates JH, Bradsher RW, et al. Chemotherapy of the pulmonary mycoses. *Am Rev Respir Dis*. 1988;138:1078-1081.
- Einstein HE, Johnson RH. Coccidioidomycosis: new aspects of epidemiology and therapy. *Clin Infect Dis*. 1993;16:349-356.

Trigger Finger: Not Always Work Related

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A retrospective chart review of 516 patients with 719 trigger fingers was undertaken to determine the relationship between trigger finger and occupation. Of the 516 patients, 361 were employed. One hundred seventy-eight (34.5%) of the employed patients had trigger fingers related to heavy lifting and/or high force gripping activities. The decision of causation is arbitrary and not based on science.

Trigger finger, or stenosing tenosynovitis, is commonly caused by a pathologically thick tendon sheath. The resulting pathology at the metacarpal phalangeal joint pulley causes a discrepancy between the size of the tendon and the pulley. This difference in size can cause the affected digit to "lock," holding the digit flexed or extended.^{1,2} Trigger digit is commonly associated with occupations that involve heavy lifting, gripping, pressure on the ligament, and occasionally with diabetes mellitus.^{3,5} From this chart review, the high prevalence of non-work-related trigger fingers clearly suggests that trigger finger is not always a work-related phenomenon.

Materials and Methods

Using patient records from 1975 to 1994, 516 patient charts with a diagnosis of trigger finger were reviewed. The purpose of this study was to determine the prevalence of non-work-related trigger finger, and from this determination find if the prevalence of non-work-related trigger finger is higher than the prevalence of work-related trigger finger. All 516 cases were patients of the senior author (MLK). The diagnosis of trigger finger was the decision of the surgeon. To illustrate, a 50-year-old male with two trigger fingers was judged to have a non-work-related condition. This patient was working as an electrician at the time of treatment and did not use his hands for heavy lifting,

or high-force gripping activities. Because the patient did not use his hands in his occupation in any of the ways that are thought to cause or contribute to trigger finger, this patient's trigger fingers were not considered work-related. In another case, a 29-year-old male patient was treated for two trigger fingers that were judged to be work-related. This patient was working as a "loin puller" on the cutting floor of a meat processing company. His job entailed very heavy work, as he used both hands in heavy lifting and high-force gripping activities. Because the patient engaged in activities in his work that were regarded as cause or contributing factors, this patient's trigger fingers were deemed work-related. In some cases, the surgeon visited a patient's place of employment or watched videos explaining the specific tasks of a patient's job to determine whether or not the patient had a work-related condition. Patients whose jobs required them to use their hands for heavy lifting and/or high-force gripping activities were judged to have work-related trigger fingers.

Results

Of the 516 patients, 313 (61%) were female and 203 (39%) were male. The overall mean age was 49 years. The mean age of females was 52 years and the mean age of males, 46 years. The youngest patient was 1 year old, and the oldest, 91 years old. Three hundred fifty-nine patients (70%) had only one finger involved. Of the 157 patients with multiple trigger fingers, 98 (19%) had two fingers involved, and 59 (19%) had more than two fingers involved. The maximum number of involved digits was nine (Table 1).

One hundred fifty-five patients were not employed at the time they were treated for trigger finger. Of the 361 employed patients, 178 were determined to have work-related trigger fingers. The majority of patients diagnosed with work-related trigger fingers were male (Table 2).

Fifty-seven patients with trigger finger also had been diagnosed with diabetes mellitus. This 11% prevalence of trigger finger related to diabetes is consistent with a previous study.⁴ Twenty diabetic patients had trigger fingers attributed to a combination of their occupations and systemic disease. Twenty-seven (47%) of the diabetic patients had multiple trigger fingers.

Discussion

Trigger finger can be attributed to many different conditions including sesamoid bones,^{6,7} tumors, anatomical variations, rheumatoid arthritis, diabetes mellitus and repeated compressive trauma to the tendon sheath and the contents.^{3,8-10} In our study, 65.5% of the patients' trigger fingers could be attributed to etiologies other than occupation. From this evidence, the cause of trigger finger is clearly not always work-related. In fact, this evidence indicates that trigger finger is frequently not the result of occupation. Therefore, the etiology is the arbitrary decision of the physician, not based on any published prospective or experimental study.¹¹

References

1. Bartell T, Shehadi S. Trigger finger secondary to anomalous lumbrical insertion: A case report and review of the literature. *Plast Reconstr Surg*. 1991;87:354-356.
2. Lapidus P. Stenosing tenosynovitis. *Surg Clin North Am*. 1953;33:1317-1347.
3. Yosipovitch A, Yosipovitch Z, Karp M, Mukamel M. Trigger finger in young patients with insulin dependent diabetes. *J Rheumatol*. 1990;17:951-952.

Table 1. Distribution Potients with Multiple Trigger Fingers

| | |
|---------------------------------------------------------|-----|
| Total number potients with more than one digit involved | 157 |
| Females | 88 |
| Males | 69 |
| Not employed | 50 |
| Employed | 107 |
| Employed ond work-related | 53 |
| Diabetic | 27 |

Table 2. Distribution of Work-Related Trigger Finger

| | |
|------------------------------------------------|-----|
| Total number potients | 516 |
| Potients not employed | 155 |
| Potients employed | 361 |
| Patients employed; work-related trigger finger | 178 |
| Males | 101 |
| Females | 77 |

4. Bonnici A, Spencer J. A survey of trigger finger in adults. *J Hand Surg*. 1988;13:202-203.
5. Rayan G. Stenosing tenosynovitis in bowlers. *Am J Sports Med*. 1990;18:214-215.
6. Flatt A. Recurrent locking of an index finger. *J Bone Joint Surg*. 1958;40A:1128-1130.
7. Flatt A. A locking little finger. *J Bone Joint Surg*. 1961;43A:240-242.
8. Kalms S, Hojgaard A. Trigger finger: report of an unusual case. *J Trauma*. 1991;31:582-583.
9. Newport M, Lane L, Stuchin S. Treatment of trigger finger by steroid injection. *J Hand Surg*. 1990;15A:748-750.
10. Weilby A. Trigger finger. *Acta Orthop Scand*. 1970;41:419-427.
11. Hill AB. The Environment and Disease: Association or Causation? *Proc Royal Soc Med*. 1965:295-300.

Pancoast's Syndrome Secondary to Thoracic Actinomycosis

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Pancoast's syndrome is almost exclusively caused by a malignant apical lung tumor invading the structures of the thoracic outlet. We report a case of thoracic actinomycosis as a cause of Pancoast's syndrome. A 65 y/o bm presented with a 6 month history of nonproductive cough, weight loss, a left upper lobe infiltrate, and a positive PPD of 20 mm. He failed to improve with triple antituberculous therapy for 3 months with worsening of left upper lobe disease. CT scan of the chest showed a mass lesion of the left upper lobe. Bronchoscopy with BAL and biopsy as well as percutaneous fine needle aspiration failed to reveal a diagnosis. Patient developed Pancoast's syndrome characterized by reflex sympathetic dystrophy with pain, swelling, and numbness of left shoulder, arm, and hand. A thoracoscopic left upper lung biopsy was performed and histologic examination revealed sulfur granules containing filamentous organisms characteristic of Actinomyces species. All sections were negative for malignancy. AFB stain and culture were negative. Patient was clinically cured following a 6-month course of penicillin with resolution of the left upper lobe mass. Although rare, thoracic actinomycosis must be considered in the differential diagnosis of Pancoast's syndrome. This case emphasizes the importance of obtaining a precise etiologic diagnosis before a treatment decision is made.

In 1932, Henry K. Pancoast, a radiologist in Philadelphia, first described a syndrome, comprising of pain and weakness of the upper extremity, and ipsilateral Horner's syndrome, caused by an apical lung lesion.¹ Pancoast's syndrome is almost exclusively caused by bronchogenic carcinoma invading the structures of the thoracic outlet. Nonmalignant causes of Pancoast's syndrome are extremely rare.

We report a case of thoracic actinomycosis as a cause of Pancoast's syndrome.

Case Report

A 65-year-old male was hospitalized with a 6-month history of nonproductive cough, 40 pound weight loss, anorexia, weakness, and pleuritic left chest pain. Patient denied fever, chills, night sweats, hemoptysis, or shortness of air. On physical examination he was a cachectic looking male with normal vital signs. Patient had poor dentition. His chest revealed equal expansion, good air entry, and bilateral rhonchi on the upper lung fields. The rest of the examination was unremarkable.

His complete blood count showed white cell count of 15,100/cu mm with 78% segmented neutrophils and 15% lymphocytes, hemoglobin of 9.5 g/dl, hematocrit of 28.7%, and platelet count of 780,000/cu mm. His erythrocyte sedimentation rate was 132 mm/hr. His blood chemistries were unremarkable. His chest radiograph showed a left upper lobe infiltrate. A PPD skin test was 20 mm. The sputum, bronchoalveolar lavage, and biopsy were nondiagnostic.

Patient was started on triple antituberculous drugs (INH, pyrazinamide, and rifampin) and was discharged home. Patient was readmitted to hospital 3 months later because of increasing weakness, progressive weight loss, and dizziness. On examination, his chest revealed decreased breath sounds and crackles on his left upper lung field. The hemoglobin was 7.3 g/dl and hematocrit 22.1%. Chest radiograph showed worsening of the left upper lobe disease (Fig 1). Patient received two units of packed red blood cells and his symptoms improved. CT scan of the chest showed a mass lesion of the left upper lobe (Fig 2). Bronchoscopy with bronchoalveolar lavage and biopsy were again nonrevealing. His hospital stay was complicated by the development of a Pancoast's syndrome, characterized by reflex sympathetic dystrophy with pain, numbness, and swelling of the left shoulder, arm, and hand. A CT guided fine needle aspiration of the lesion was

nondiagnostic. A thorascopic left upper lung biopsy was performed. Histologic examination revealed sulfur granules containing filamentous organisms, characteristic of *Actinomyces* species (Fig 3). All sections were negative for malignancy. The AFB stain was negative. All cultures were negative. The patient was treated with high doses of intravenous penicillin G for 4 weeks, after which his treatment was changed to oral penicillin. Patient was clinically cured following a 6 month course of treatment. The follow up chest radiograph showed resolution of the left upper lobe disease.

Discussion

The signs and symptoms of Pancoast's syndrome are due to the involvement of brachial and sympathetic plexuses of nerves either by pressure or by invasion by a tumor.² Pancoast's syndrome is most often caused by a primary lung carcinoma.³



Fig 1 — Thoracic Actinomycosis Left Upper Lobe Infiltrate on CXR.

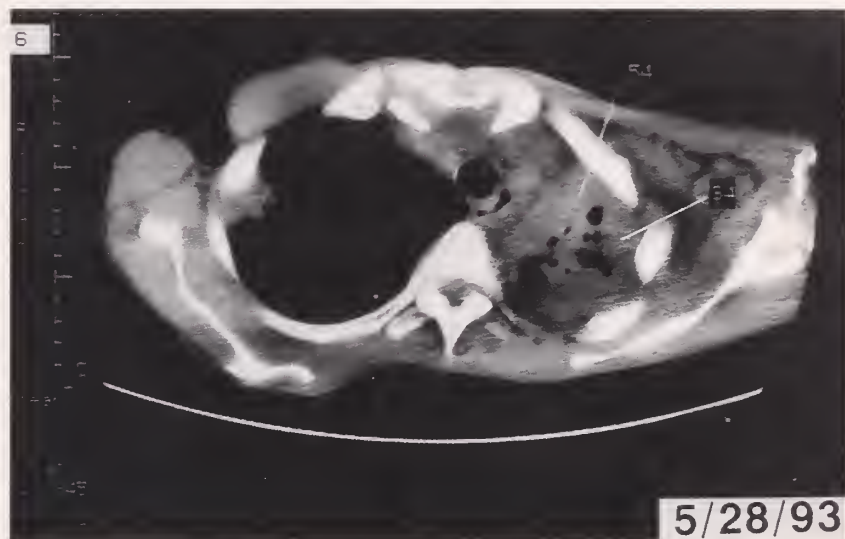


Fig 2 — Thoracic Actinomycosis Left Apical Cavitary Lesion on CT scan.

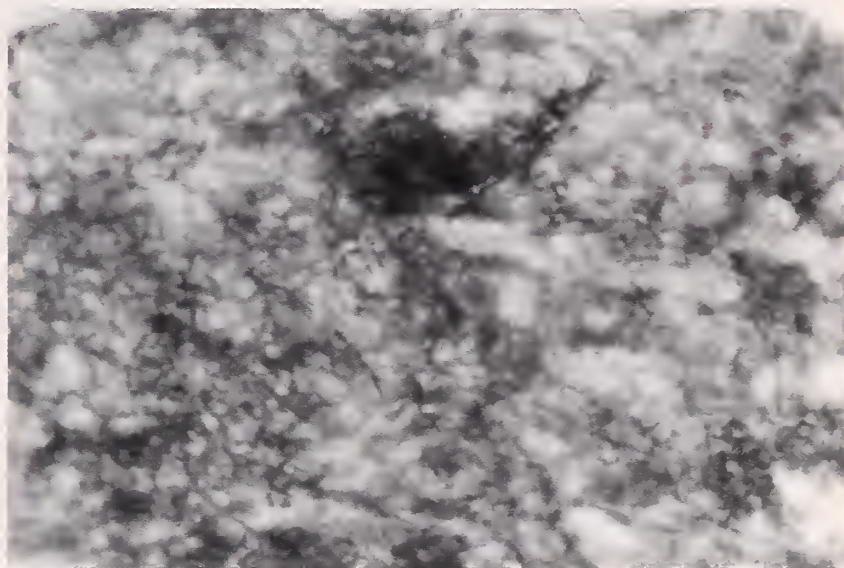


Fig 3 — Actinomyces species Gram Positive Filaments with Sulfur Granules.

However, other malignant tumors have been reported to cause Pancoast's syndrome. These include mesothelioma,³ Hodgkin's lymphoma,³ thyroid carcinoma,³ multiple myeloma,⁴ and metastatic tumors.⁵

Nonmalignant causes, although rare, have also been recognized. Apical lung infections by *Mycobacterium tuberculosis*,¹ *Pseudomonas aeru-*

Pancoast's Syndrome

ginosa,⁶ and *Staphylococcus aureus*⁷ have been reported to produce this syndrome. Fungal infections with *Allescheria boydii*, *mucormycosis*, and *invasive aspergillosis in immunosuppressed patients*⁸ have also been implicated. A locally invasive infection with *Cryptococcus neoformans* in a normal host has been reported.⁹

Pancoast's syndrome secondary to thoracic actinomycosis is extremely rare. To our knowledge, only two similar cases have been reported. One of the patients presented with a 6 month history of sharp left neck and facial pain which gradually extended into the left shoulder and arm.¹⁰ The other patient presented with a right anterior chest nonhealing ulcer and weakness of the right hand.¹¹

Despite the absence of Horner's syndrome in our patient, the clinical findings were similar to those described by Pancoast. In retrospect, the only suggestion that our patient might have thoracic actinomycosis was his poor dentition. Sputum examination, repeated bronchoscopy with bronchoalveolar lavage and biopsy as well as fine needle aspiration failed to reveal a diagnosis in our patient. At that point, there was a long discussion about the need for further diagnostic work up, since malignancy was the utmost consideration. Finally, a more invasive diagnostic procedure was performed and it revealed a diagnosis of thoracic actinomycosis.

Conclusion

This case report illustrates a rare but treatable cause of Pancoast's syndrome. It emphasizes the importance of obtaining a precise etiologic diagnosis before treatment decisions are made.

References

1. Pancoast HK. Superior pulmonary sulcus tumor. *JAMA*. 1932;99:1391-1396.
2. Hepper NG, Herskovic T, Witten DM, et al. Thoracic inlet tumors. *Ann Intern Med*. 1966;64:979-989.
3. Herbut PA, Watson JS. Tumor of the thoracic inlet producing the Pancoast's syndrome: a report of 17 cases and a review of the literature. *Arch Pathol*. 1946;42:88-103.
4. Brenner B, Carter A, Freidin N, Malberger E, Tatarsky I. Pancoast's syndrome in multiple myeloma. *Acta Haemat*. 1984;71:353-355.
5. Omenn GS. Pancoast's syndrome due to metastatic carcinoma from the uterine cervix. *Chest*. 1971;60:268-270.
6. Vandenplas O, Mercenier C, Trigaux J-P, Delaunois L. Pancoast's syndrome due to *Pseudomonas aeruginosa* infection of the lung apex. *Thorax*. 1991;46:683-684.
7. Gallagher K, Jeffrey R, Kerr K, Steven M. Pancoast syndrome: An unusual complication of pulmonary infection by *Staphylococcus aureus*. *Ann Thorac Surg*. 1992;53:903-904.
8. Shamji FM, Leduc JR, Bormanis J, Sachs HJ. Acute Pancoast's syndrome caused by fungal infection. *Can J Surg*. 1988;31:441-443.
9. Mitchell D, Sorrell T. Pancoast's syndrome due to pulmonary infection with *Cryptococcus neoformans* variety *gattii*. *Clin Infect Dis*. 1992;14:1142-1144.
10. Eiben C, Indihar F, Hunter S. Thoracic actinomycosis mimicking the Pancoast syndrome. *Minn Med*. 1983;66:541-544.
11. Stanley jun S, Lusk R. Thoracic actinomycosis presenting as a brachial plexus syndrome. *Thorax*. 1985;40:74-75.

THINK — About Tunnel Vision

Several recent instances have called to mind an interesting but somewhat disturbing phenomenon of human nature as it pervades medical practice. As we progress through our years of training, specialization, and practice, I believe we become so entangled in our daily routines and so intent on our own subspecialty that we cannot see the veritable "forest for the trees" as they say. We acquire our own individual form of tunnel vision. We somehow manage to bring only certain pieces of the puzzle to the table, forgetting that these pieces are essentially worthless individually. I see this with myself and my medical colleagues as easily as in my six-year-old daughter and my two-year-old son. It will always be easier to say "This is not my problem" and to locate someone else to accept the responsibility. It concerns me deeply that very often we find that we have ultimately relinquished our responsibility to think.

I recently have had a consulting physician colleague say to me, "That is not my problem; it is not my subspecialty area." The other response I always like is, "Well, I was waiting for someone to tell me I had to do that." Or the recent call I received from a physician's secretary to call him back so I could tell him about a certain subject — which of course fills an entire chapter in

Harrison's Textbook of Internal Medicine.

I am in no way implying that although we were all trained as physicians that I could anymore step out of my pathology office and do open-heart surgery anymore than I would expect any of you to come into my office and read a frozen section on an ovarian neoplasm. I must say that I countered the request from the physician's secretary to discuss a particular subject with him. I kindly reminded him that the *Harrison's Textbook of Internal Medicine* was available in the medical library and if, after that point, he needed help with other areas I'd be happy to help. I think I'm perfectly capable of picking up a copy of *Schwartz's General Surgery* text in order to make myself more familiar with a particular surgical technique. Many of these comments are a throwback to the days of my general surgery intern year when if you were on a subspecialty surgical service you had to call the general surgery resident to pull out the nasogastric tube!

Our patients today are extremely complex. They often arrive with a plethora of disease states with multiple manifestations. It certainly takes all of us together sharing in their care to provide the best in diagnoses and treatment.

Every year I give a lecture to first-

"It concerns me deeply that very often we find that we have ultimately relinquished our responsibility to think."

year medical students that is essentially a clinicopathologic correlation for their early work in anatomy and histology. I try to remind them, just as someone long ago reminded me, that I was not in this profession in order to make "good grades" or to "look good in front of my peers." Instead I try to remind them that they are learning material so that they can become good physicians. And part of being a good physician is accepting the responsibility to think. We should never give up our zeal to learn more, even if it's out of our own venue; even if it means a bit of struggle and a bit of time out of our normal routine. If we wait for someone to tell us we have to do the task or we fail to look at the patient as a whole, then we have failed as physicians.

Carolyn D. Burns, MD

Life After Medical School

Leonard Laster, MD

W. W. Norton & Company, Inc
500 Fifth Avenue
New York, NY 10110
320 pp, \$27.50

Dr Laster, the Chancellor Emeritus of the University of Massachusetts Medical Center, creates in this book a touching and very cogent view of the medical profession.

Although each of us carries a story of our path to medicine, there are similarities and associations common to many of us. Reaching the decisions demanded hours of thought, experience in the field, personal interactions, genetics, and the nebulous "timing." Probably reading this book might have smoothed out some of the bumps on the road. In these pages, 32 physicians tell their stories, in a voice that seems to be like a fireside chat. Personal, yet factual, direct and gentle, each story seems to flow on through the words and end with a unique perspective. The individuals speaking represent many, if not all, of our members, and in this rather complete senate of authors, the final product encompasses most types of experience. That each of our stories differs from these only makes the comparisons more interesting. In the smorgasbord of medical professional

choices, picking sometimes seemed impossible, yet enticing. How we arrived at that choice, and how the authors came to theirs, makes for familiar and reassuring reading.

Medical students should read this book, not only for help along the way, but for comfort that their turmoils have an ending, that their questions can be clarified, if not answered. For our digestion, this book is almost a dessert, having made our plate. Never give up the opportunity to learn from your peers.

Hip and Knee Replacement A Patient's Guide

*Geoffrey McCullen, MD
Ryle Miller, Jr
Drawings by Dolly Miller*

W. W. Norton & Company, Inc
500 Fifth Avenue
New York, NY 10110
128 pp, \$19.95

This compact book represents the collective effort of the authors to place a primer in the hands of patients facing total joint replacement. With technical information available and much casual reporting in the press, some fusion of the physician's perspective with the patient's ability to comprehend proved useful. Four

sections divide the book into both readable and referenced parts. Drawings and some tables illustrate the anatomy and the jargon for the less sophisticated. Most patients come to this decision point, having heard these names and felt many examinations of their joints. To be on some par with their treating surgeon makes the explanations flow smoothly. Also the alternatives to surgery can be compared with some ability. The nitty-gritty of the insurance, time from work, incapacity, and requirements for post operative assistance take some precedence before the operation, if only to ease the depressing part of handling the details.

Operations shown on cable are dramatic, but the written word lingers for the reader to refer and to reconsider. Enough detail comes in this part, without a deluge that floods the overwhelmed reader. From the pain to the rehabilitation albatross, the dark side of these procedures balances the cavalier suggestion of "get a new one" when the old one fails. Although I do not face this dilemma now, who can tell that someday this onerous predicament may be mine.

That such a book exists encourages other basic writings for our patients to be a partner in making medical decisions.

Stephen Z. Smith, MD
Book Review Author

S.M.A.R.T.

It is an unparalleled privilege to focus the spotlight on Kentucky Medical Association Alliance members who respond so vigorously and unselfishly to the numerous health challenges of our time. S.M.A.R.T., an acronym for *Students Made Aware Reject Tobacco*, is a unique health education, antismoking program developed and implemented by two dynamic Fayette County Medical Society Alliance members, Mary Gus (Mrs Richard F.) Smith, RN, MSPH, and Ginny (Mrs Martin J.) Luftman, RN, MSN.

Targeted toward middle school students 11 to 14 years old, S.M.A.R.T. not only enjoys tremendous success on a county level, but has gained state and national recognition as well. This innovative program has been adopted by the American Lung Association and implemented by other Kentucky Medical Society/Association Alliances, including Jefferson, McCracken, and Pulaski.

S.M.A.R.T. is an upbeat, gut-level, slide-video and interactive presentation that educates teenagers about the physiological, cosmetic, social, and economic effects of smoking and smokeless tobacco use. It wisely contains a critical component, the teaching of refusal skills.

The issues that S.M.A.R.T. instructors address include:

- Health effects of tobacco: emphysema, heart disease, cancer, bronchitis;
- Cosmetic and other effects of tobacco: bad breath, smelly hair, yellow teeth, premature wrinkles, decreased sports stamina, less spending money, trouble with parents;
- Hazards of second-hand smoke;
- Tobacco advertising; why is it directed at kids and what to do about it;
- How to say no.

The health education project



Ruth Ryan

S.M.A.R.T. manifests the most significant contribution that a member can make to his/her spouse's profession — hours of time, energy, and expertise so freely shared in the service of others. We applaud Mary Gus Smith and Ginny Luftman for their sustained efforts in that direction and wish them continued success in their endeavors.

Ruth Ryan
KMAA President



Pictured are Fayette County Medical Society Alliance members Mary Gus Smith (far left), and Ginny Luftman.

PHYSICIAN'S RECOGNITION AWARDS

Listed below are KMA member physicians in Kentucky who have earned the AMA's Physician Recognition Award (PRA) from August 1995 through July 1996.

The Award was established by the AMA House of Delegates of the American Medical Association in 1968 "to encourage physician participation in continuing medical education and to recognize physicians who have voluntarily completed programs of continuing medical education." In December 1992, the AMA House of Delegates revised the requirements for the PRA. Physicians now have two choices for PRA certification — the standard certificate and the PRA certificate "with Special Commendation for Self-Directed Learning." A minimum of 150 credit hours of CME must be earned over a consecutive 3-year period to qualify for the Standard PRA Certificate. Of these 150 hours, at least 60 must be in AMA/PRA Category 1. Ninety hours of education can be

Allen

Earl P. Oliver, MD

Anderson

Kenneth E. Hines, MD

Barren

Warren J. Eisenstein, MD
Jerry L. Gibbs, MD
Michael W. Shadowen, MD

Boone

Chris Wong, MD

Bourbon

Emmett L. Tate, MD

Boyd

Cheryl L. Cook, MD
Robert J. Thomas, MD
Max E. Wheeler, MD

Boyle

Richard E. Nallinger, MD
Roger J. Pentzien, MD

Breckinridge

Robert B. Chambliss, MD

Bullitt

Constancio Bautista, MD

Caldwell

Algimantas L. Jecius, MD

Campbell

Jerry W. Connors, MD

Watson M. Gutowski, MD

Robert G. Sopko, MD

Carroll

Cecil D. Martin, MD

Christian

John E. Cotthoff, MD
Nabil W. Malek, MD
Sean S. May, MD
Jonathan N. Terhune, MD

Crittenden

Gary V. James, MD

Clark

Harold S. Moberly, MD

Daviess

Charles M. Millsap, MD
R. J. Phillips, MD
Robert L. Reid, MD

Fayette

Keith J. Alexander, MD
Robert J. Bunge, MD
Robert C. Burkhardt, MD
William K. Burkhardt, MD
Marshall A. Dawson, MD
Louis D. Dubilier, MD
Frank Garamy, MD
Kenneth V. Hughes, MD
Van R. Jenkins, MD
Karl C. Kely, MD
Christian N. Ramsey, MD
Nat H. Sandler, MD
Richard F. Smith, MD

Garnett J. Sweeney, MD

Woodford S. Van Meter, MD

Alexander L. Vigh, MD

Jeffrey L. Winters, MD

William L. Wittman, MD

Floyd

Narong Chalothorn, MD
Steven A. Conrotto, MD
Kenneth T. Grimes, MD
Steve L. Roberts, MD

Franklin

James M. Fetter, MD
Rice C. Leach, MD

Grant

Darl B. Shipp, MD

Grayson

Kenneth M. Sample, MD

Greenup

Robert J. Thomas, MD

Hardin

Tom E. Hall, MD
William C. Nash, MD
Khue N. Tran, MD

Harlan

Yung-Poe Lee, MD

Henderson

William J. Brennan, MD
Noel D. Canlas, MD
John A. Price, MD

in Category 2 which includes CME lectures and seminars not designated Category 1; medical teaching; articles, publications, books, and exhibits; and nonsupervised CME such as self-instruction, consultation, patient care review, and self-assessment. Credit hours are based on hour-for-hour participation in a continuing medical education activity with the number of hours rounded to the nearest whole hour. For the new Special Commendation Certificate, the requirements differ from the Standard Certificate in that applicants cannot include reading of medical literature as qualifying for Category 2 and applicants had to obtain a minimum of 20 credit hours of Category 1 and 20 credit hours of Category 2 annually.

We congratulate these physicians who have distinguished themselves and their profession by their commitment to continuing education.

Hopkins

Richard C. Bauer, MD
Ronald A. Berry, MD
William H. Klompus, MD

Jefferson

Mahesh Agrawal, MD
Elizabeth A. Amin, MD
Mohammad Amin, MD
Archana Barry, MD
Carolyn D. Blair, MD
Karen L. Kaye Bloom, MD
Jeffrey P. Callen, MD
Norman K. Cohen, MD
Thomas D. Cummins, MD
Clarence E. Denton, MD
Francisco Elbl, MD
Martin S. Fox, MD
Katherine M. P. Garrison, MD
Robert R. Goodin, MD
Diller B. Groff, MD
Geoffrey L. Hulse, MD
William A. Hymes, MD
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Bothwell G. Lee, MD
Thomas M. Loeb, MD
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Herbert T. Maguire, MD
Martin D. Mark, MD
Soraya P. Nasraty, MD
Syed M. Nawab, MD
Robert R. Riedle, MD
Dale M. Roberts, MD
Frank D. Rollo, MD
Victor J. Shpilberg, MD
David A. Spain, MD

James L. Sublett, MD
Allan Tasman, MD
Joseph L. Thompson, MD
Tsu M. Tsai, MD
Robert R. Wahl, MD
Ralph E. Whitehead, MD
Nathan Zimmerman, MD

Kenton

Christine Horner-Taylor, MD
Robert T. Longshore, MD

Laurel

Susan A. Adeife, MD

Madison

Clifford F. Kerby, MD

McCracken

David C. Waggoner, MD

Muhlenberg

William L. Miller, MD

Ohio

Eric A. Norsworthy, MD

Perry

Elizabeth B. Shelly, MD

Pike

Harry E. Altman, MD
James S. Shockey, MD
Erlindo G. Valera, MD
Remedius M. Valera, MD

Pulaski

Rodney J. Oakes, MD

Rockcastle

Kimberly Cornelius, MD

Russell

Richard S. Miles, MD

Taylor

David E. Bentley, MD
Henry F. Chambers, MD
James A. Ewing, MD

Warren

Mark T. Alberhasky, MD
Kenneth K. Bartholomew, MD
Robert J. Emslie, MD
Pippa Pinckley-Stewart, MD
John C. Tapp, MD

Whitley

C. William Briscoe, MD

PEOPLE

Roberto Bolli, MD, cardiovascular diseases, has been designated the University of Louisville's first Distinguished University Scholar. Dr Bolli came to the University of Louisville in 1994, bringing with him training at the National Heart, Lung and Blood Institute, experience as a Baylor University School of Medicine faculty member, an international reputation as a cardiology researcher, and substantial support from the National Institutes of Health.

Dr Bolli's research centers on the role of oxygen-derived free radicals, their production in the bloodstream, and their interaction with heart muscles after blood flow to an area of the heart is blocked, then restored. He developed a methodology that would allow researchers to measure the volume of free radical production and the activities of free radicals in living organisms during a block-unblock episode. He demonstrated that the magnitude of oxygen free radicals generated in the first 10 minutes after blood flow is restored is an indicator of the severity of the damage to heart tissue. And he succeeded in showing that administration of antioxidants could limit the production of free radicals immediately after a block-unblock episode and lessen the damage done.

Dr Bolli and a colleague now are investigating the feasibility of genetic and molecular therapies for heart ailments.

Hoyt D. Gardner, MD, received the Irvin Abell, Sr. Award during the U of L School of Medicine Alumni dinner. The award, presented each year, honors a graduate who exhibits qualities of humanitarianism and public service in his career. Dr Gardner served as president of AMA, KMA, and JCMS.

Will W. Ward, Jr, MD, and The Healing Place directors, Jay Davidson and Chris Fajardo recently met with Chicago's Father George Clements, Governor Paul Patton **and Lt.**

Governor Steve Henry to discuss implementing Fr. Clements' "One Church — One Addict" in Kentucky.

"One Church — One Addict" recruits churches of all denominations to join the battle against substance abuse by establishing and training team ministries in the community.

Fr. Clements founded "One Church — One Child," a national adoption program that led to 40,000 children being placed in 10 years. In 1994 when he began "One Church — One Addict," he visited The Healing Place, a Jefferson County Medical Society Outreach Program in Louisville, to learn more about drug and alcohol recovery.

The American Contact Dermatitis Society voted **Joseph F. Fowler, Jr, MD**, president-elect. His term runs from March 1997 to March 1998. Dr Fowler is an Associate Clinical Professor of Dermatology at U of L and co-author of the textbook, *Fisher's Contact Dermatitis, Fourth Edition*.

The Kentucky division of the American Cancer Society named **T. Jeffrey Wieman, MD**, president-elect of the 1996-97 board of directors. Dr Wieman is medical director of the Norton Hospital Cancer Treatment Center, Louisville.

released a set of guidelines for physician joint ventures. These new guidelines incorporate important points for which the American Medical Association has lobbied for more than 3 years.

Under the new guidelines:

- For the first time, noncapitated physician ventures will be judged by the rule of reason rather than being viewed as *per se* illegal when a single price for services is agreed upon. The new statement says that "it is unlikely" that joint ventures in competitive markets would raise substantial antitrust concerns.
- Networks of physicians as large as 50% will be viewed as reasonable in competitive markets if they are nonexclusive and meet standard joint venture criteria.
- The agencies acknowledge that the market for medical services has significantly changed and that there are substantial benefits of physician joint ventures that patients should be given the option of selecting.

Daniel H. Johnson, MD, AMA President, commented, "This action represents a milestone, but we still have a way to go before we reach a level playing field. The health care market is undergoing rapid changes. Antitrust and other regulatory policies will require deeper adjustments. It should be noted that the new antitrust guidelines represent defeat of an intense insurance industry campaign to block changes in policy. Physician networks now have a great chance to compete effectively with commercial companies, and expand the range of choices available to our patients."

UPDATES

AMA Persistence Brings New Antitrust Rules

The US Department of Justice and the Federal Trade Commission have

Multidisciplinary Teams to Investigate Child Sexual Abuse

The Cabinet for Families and Children (formerly Cabinet for Human Resources) is encouraging physicians to participate on local multidisciplinary teams to investigate child sexual abuse.

Legislation enacted by the 1994 General Assembly requires investigation of reported or suspected child sexual abuse to be conducted by specialized multidisciplinary teams. Approximately 60 counties have begun efforts to develop multidisciplinary teams on child sexual abuse.

If you are interested in offering your services to a local multidisciplinary team, contact your local Department for Social Services or your local law enforcement agency.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Hardin

Shad Jawaid, MD — IM
800 W Lincoln Trail Blvd Ste 102,
Radcliff 40160
1986, U of Port Harcourt

Jefferson

Howard S. Lazarus, MD — OPH
519 State St, New Albany 47150
1986, Northeastern Ohio U

Kenton

Lana L. Long, MD — D
1938 Mount Vernon, Fort Wright 41011
1988, U of Missouri at Columbia

Laurel

Aqeel H. Mandviwala, MD — PUD
1808 Mallard Dr, London 40741-9748
1985, Dow, Pakistan

Perry

Mahender Pampati, MD — R
200 Medical Center Dr Ste 1N, Hazard
41701
1980, Magadh, India

Whitley

Nasir H. Gardezi, MD — IM
1708 Forrest Dr, Corbin 40701
1977, Nishtar, Pakistan

DEATHS

W. Vernon Lee, MD
Covington
1913-1996


W. Vernon Lee, MD, a retired general surgeon, died January 26, 1996. Dr Lee was a 1944 graduate of the University of Wisconsin Medical School and a life member of KMA.

Willard F. Chumley, MD
Owensboro
1931-1996

Willard F. Chumley, MD, a radiologist, died April 22, 1996. A 1956 graduate of the University of Louisville School of Medicine, Dr Chumley was an active member of KMA.

William Francis Clarke, MD
Lexington
1921-1996

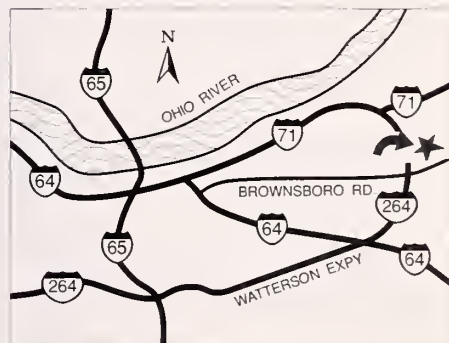
William Francis Clarke, MD, an internist, died August 2, 1996. Dr Clarke graduated from the University of Louisville School of Medicine in 1945 and was an active member of KMA.



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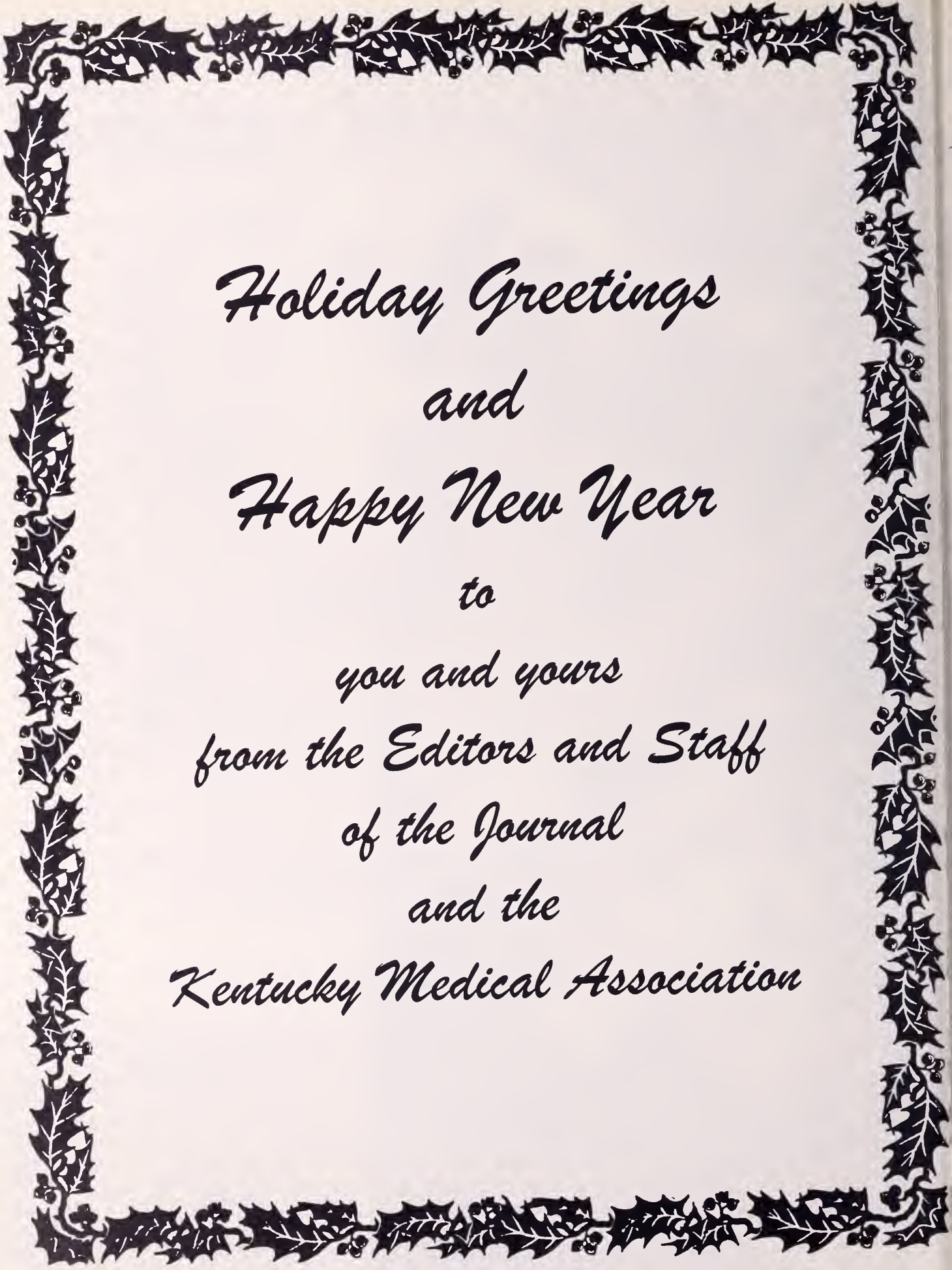


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DECEMBER 1996

| | | |
|-------------------------|--------------------------------------------------------------------------------------------------------------------------------|------------|
| SCIENTIFIC | ECG Intervals in Acute Bipolar and Schizophrenic Relapse <i>Rif S. El-Mallakh, MD; Shahram Sepehri; Steven Lippmann, MD</i> | 526 |
| EDITORIAL | Everybody Out of the Pool! <i>Milton F. Miller, MD</i> | 529 |
| SPECIAL FEATURES | Delegate Roll Call | 546 |
| | Digest of Proceedings, 1996 House of Delegates | 549 |
| | Index to Proceedings and Reports | 550 |
| | Index to Resolutions | 551 |
| | Index to <i>Journal</i> Volume 94 — 1996 | 606 |
| | KMA 1996-97 Organization Chart | 603 |
| | KMA Reference Committees | 552 |
| ASSOCIATION | <i>Monitoring Medicine</i> | 523 |
| | 146th KMA Annual Meeting | 534 |
| | In Memoriam | 525 |
| | 1996-97 Committees | 601 |
| DEPARTMENTS | President's Page | 521 |
| | Advertisers' Guide | 608 |
| | Alliance Page | 531 |
| | Classifieds | 605 |



COVER: This issue of the *Journal* provides extensive coverage of the 146th Annual Meeting, which was held in Louisville on September 26-28. An overview begins on page 534, with House of Delegates coverage beginning on page 549. Cover art by Lee Wade.

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William H. Mitchell, MD

Who are "Milliman & Robertson" and How Did They Get In My Face?

Any physician who has a managed care contract has had the experience of being informed by an insurance company that a hospitalized patient has exceeded the "length of stay (LOS) guideline." This information is usually communicated to the physician by a professional utilization review nurse who works for the hospital or the insurance company. The communication is, for the most part, received by the doctor with the same graciousness that general Rommel's panzer army gave up North Africa.

Exceeding the LOS does not mean that the patient must be dismissed. It means that, unless the clinical documentation to justify acute care can be provided, the company will not pay for any additional in-hospital services.

That much is clear enough, but who comes up with the "length of

stay" and other "managed care" guidelines? Currently, the major source of this type of information is provided by Milliman & Robertson, Inc (M&R). This organization provides insurance companies with data that is used to determine what to cover and what not to cover. M&R Guidelines are used by health plans in many states; health plans like Blue Cross/Blue Shield, Kaiser, CIGNA, Prudential, and US Healthcare. These M&R Guidelines directly influence the coverage policies for more than 50,000,000 Americans.

So, who are these guys? When did this start? How big is this outfit? Well, M&R is a firm of actuaries and consultants serving the full spectrum of business, governmental, and financial organizations. Founded in 1947 and incorporated in 1957, the firm has 26 offices in the United States, plus 1 office in Bermuda and 1

in Japan. M&R is the US and Japanese member of Woodroe Milliman, an international network of actuaries and consultants. M&R's revenues exceed \$165,000,000 and Woodroe Milliman's worldwide revenues exceed \$300,000,000.

The company's practice areas include the following:

1. Pension, employee benefits and compensation consulting services
2. Health Consulting Services
3. Property/Casualty Consulting Services
4. Life and Financial Consulting Services

M&R has 28 offices in the United States and, as a member of Woodroe Milliman, has access to 98 worldwide offices.

The organization is managed by 67 principals who own 80% of the firm. The remainder of the firm is

“This is the kind of language we need to learn if we are to effectively interact with managed care changes. Whether we agree with this evolution or not, we must seek to understand it.”

owned by 100 key professionals who have been elected in recognition of their technical and professional achievement.

Milliman & Robertson has approximately 1,100 employees in the United States, Bermuda, and Japan, including a professional staff of more than 450 actuaries and consultants. Woodroe Milliman has more than 2,500 employees worldwide.

So, Milliman & Robertson, Inc is a reasonably good-size company, with more than a trivial capacity to influence managed care coverage.

Utilization review is evolving to utilization management, and ultimately will become incorporated into a comprehensive continuous quality improvement program.

It is becoming increasingly important to identify the “best observed practices” and use the knowledge to influence the efficiency of health care delivery systems. M&R seeks to identify the “best observed practices” through on-site review and national physician advisor input. This information is used to generate “optimal recovery guidelines” (ORG). ORGs are clinical profiles for best case scenarios in the management of hospitalized patients. It is from these ORGs that the length of stay is projected. It is on the basis of the

ORG that clinical information obtained in the utilization review process is applied to medical necessity for insurance coverage.

These guidelines can be used to evaluate and benchmark the efficiency of providers, develop a physician evaluation program based on a degree of compliance with the guidelines, and provide performance feedback. A provider performance incentive program can be initiated based on this evaluation and substantiated using M&R's clinical techniques.

This is the kind of language we need to learn if we are to effectively interact with managed care changes. Whether we agree with this evolution or not, we must seek to understand it. With a proper understanding we can either seek to develop such a system or change it. This is the type of information to which physicians need access and upon which we need to focus our attention. We need to be aware of what these “optimal recovery guidelines” are. If modifications are needed, we need to be able to express our concerns from a position of factual knowledge and focused study.

William H. Mitchell, MD
KMA President

MONITORING MEDICINE

NEWS FOR KENTUCKY PHYSICIANS

Comprehensive School Health Education

COMMUNITY LEVEL ACTION SHEET

KENTUCKY MEDICAL ASSOCIATION TASK FORCE ON CSHE

Thomas L. Young, MD, Chair

THE CHARGE: The bottom line in CSHE begins at the local level. Our children and their families have unhealthy lifestyles. Education that is sequential, comprehensive, and integrated into preschool through high-school education is required if we plan to equip children with skills to be healthy, whole individuals. Physicians are key to successful implementation at this local level.

THE BACKGROUND: It is clear that unhealthy lifestyles account for more than 50% of early mortality of our children. It is also intuitively obvious that single intervention cannot change these lifestyles. Issues of violence, low self-esteem, smoking, drug abuse, suicide, etc, need consistent, persistent educational efforts to alter these undesired outcomes. The American Cancer Society (ACS) conducted a Gallop-poll of school health education in 1994. The results showed very strong support for CSHE by parents, students, and school administrations. Over 80% of each group said that health education was of equal importance or more important than other academic subjects. Who better to lead the efforts to promote health than physicians? By collaboration with parents and other community leaders, we can make a difference. The following actions should help

you through the process to better health through comprehensive school health education.

SPECIFIC ACTIONS:

- ☐ Identify and contact local school district health coordinator: Find out what health education is occurring in schools, who makes health education decisions, and who in the school district is interested in health education (ie, school nurse, school administrator).
- ☐ Develop or join, if existing, a school health advisory board, under the auspices of the school district. Ask superintendent or school board to authorize this board. Suggested members, each who has an interest in health education include: physicians, school nurses, dentists, psychologists, parents (ie, PTA), teachers (particularly health), child advocates, business leaders, etc.
- ☐ Encourage parents to find out what their child is being taught about health at school and enlist their support for CSHE. (PTA pamphlets called ("Healthy Children, Successful Students") is an excellent resource to give out to parents).
- ☐ Do a health needs assessment to define local health issues. Local data has more meaning to local communities. Assess smoking rates,

KMA

drug use, teen pregnancy, suicide, violence, etc. Consider asking the school to administer the Youth Risk Behavior Survey, available through CDC.

- ☐ Enlist local media to inform them of child health concerns. Once they are informed, ask them to support the advisory council recommendation for CSHE.
- ☐ Consider being a school medical advisor to develop support within the school administration structure. This can be rewarding and very helpful toward reaching CSHE goals.
- ☐ Contact KMA chairperson of the Child and School Health Committee. This person can put you in touch with other physicians in your state working at the local level. You can learn from their experience.

- ☐ American Cancer Society has published national standards for CSHE. These will be useful to you. A copy can be obtained from ACS. ACS has also completed a Gallop-poll of parents and administrative opinion on CSHE. It is very good and is available from local or state ACS offices.

RESOURCES:

- ☐ AAP-Legislative Packet on School Health Education (1-800/443-9016). Ask for Division of Government Affairs (AAP Members can receive one free) — Excellent, A MUST (contains ACS Gallop-poll and Health Education Standards).
- ☐ American Cancer Society (1599 Clifton Road, Atlanta, GA 30329) — A state CSHE

coordinator and task force should be in place in each state.

Kentucky ACS office is in Louisville (502/584-6782).

- ☐ Holly Conner (Kentucky Department of Education) — Resource Library (502/564-3791)
- ☐ National School Board Association (1680 Duke Street, Alexandria, VA 22314) — Several publications available on CSHE. (703/838-6722)
- ☐ CDC— Division of Adolescent and School Health — Good resource and up-to-date information. They are developing CSHE Guidelines. — Copy of state specific Youth Risk Behavior Survey. (404/488-5327)
- ☐ KMA Committee on Child and School Health.

In Memoriam

Do not seek death. Death will find
you. But seek the road which
makes death a fulfillment.
—Dag Hammarskjöld

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ECG Intervals in Acute Bipolar and Schizophrenic Relapse

Rif S. El-Mallakh, MD; Shahram Sepehri; Steven Lippmann, MD

From the Mood Disorders Research Program, Department of Psychiatry & Behavioral Sciences, University of Louisville School of Medicine, Louisville, KY 40292.

Psychosis in general and acute relapse of bipolar illness, in particular, are associated with elevated catecholamine excretion, cardiovascular changes, and changes in intracellular calcium concentration. In an effort to determine if these changes result in observable ECG abnormalities, we retrospectively examined ECG parameters of acutely disturbed bipolar and schizophrenic patients. There were no discrete patterns of abnormalities, and no significant differences were observed between the two patient groups. Most ECG changes in acutely hospitalized bipolar and schizophrenic patients appear to be benign.

Acutely manic bipolar patients have been reported to excrete greater amounts of urinary 3-methoxy-4-hydroxyphenylglycol (MHPG),^{1,3} a major metabolite of epinephrine and norepinephrine.^{4,5} These patients also appear to have elevated intracellular calcium (Ca) as measured in platelets and lymphocytes during periods of mania or depression.^{6,8} Acutely psychotic individuals with bipolar illness or schizophrenia tend to have elevated heart rates and blood pressure at the time of presentation.^{9,10} Finally, bipolar patients may also have an increased rate of cardiovascular morbidity. For example, 20% of elderly bipolar patients suffer from hypertension.¹¹

Bipolar illness, in particular, appears to be associated with a wide range of other ion regulation and distribution abnormalities than can be associated with cardiovascular problems.¹²⁻¹⁵ These changes include altered activity of the sodium- and potassium-activated adenosine triphosphatase (Na,K-ATPase),^{12,13} calcium ATPase,¹⁴ and intracellular sodium (Na).¹⁵ These anomalies have been purported to play a role in the pathophysiology of bipolar illness, and several authors have presented compelling theoretical arguments

that ion dysregulation may be key to symptom production in this disease.^{13,16,17}

While electrocardiograms (ECGs) of acutely manic or depressed patients show no gross abnormalities,⁹ detailed examination of ECG parameters has not been done. In a preliminary effort to determine if ECG parameters are associated with alterations that may reflect alterations in catecholamine and ion homeostasis, we conducted a retrospective study of the electrocardiogram (ECG) in acutely ill bipolar and schizophrenic subjects.

Methods

Ninety-six consecutive patient admissions to a large university hospital psychiatric unit in 1992 with a diagnosis of bipolar illness or schizophrenia were reviewed. Since we wanted to examine the effects of the ill state on the ECG, we excluded 17 charts that did not have an ECG documented within 3 days of admission. We omitted 18 additional records (11 bipolar, 7 schizophrenic) that had clinically significant abnormal tracings which reflected cardiovascular diseases (eg, atrial or ventricular hypertrophy or old infarcts). With the exception of a patient demonstrating a prolonged QT interval and a serum lithium level of 2.0 mEq/L, the excluded abnormalities did not appear to be related to medications. Data analysis was performed on the remaining 61 cases (64% of the initial population) of which 29 had borderline ECG abnormalities. In addition to demographics, medications at the time of the ECG, and discharge diagnoses, data were also collected regarding heart rate, P, QRS, and T wave durations, and PR, QT and corrected QT (QT_c) intervals. Due to the retrospective nature of the data and frequent concurrence of manic and depressive symptoms, we were unable to examine bipolar depressed and manic patients separately. These individuals were combined into a single, ill bipolar group.

Table 1. ECG variables among acutely disturbed bipolar and schizophrenic inpatients (all values as means \pm SEM)

| Patient Group (#) | Heart Rate (beats/min) | P Wave (msec) | PR* (m sec) | QRS (m sec) | QT (m sec) | QTc (m sec) | T Wave (m sec) |
|---------------------|------------------------|-----------------|-------------------|------------------|------------------|------------------|------------------|
| Bipolars (N = 30) | 82.0 \pm 2.56 | 75.0 \pm 2.73 | 158.2 \pm 3.63 | 83.5 \pm 1.33 | 351.4 \pm 5.17 | 406.5 \pm 3.90 | 160.7 \pm 3.54 |
| Schizophrenics (31) | 77.8 \pm 2.78 | 76.1 \pm 2.40 | 153.67 \pm 3.27 | 87.52 \pm 1.66 | 353.8 \pm 4.88 | 397.9 \pm 4.40 | 159.3 \pm 3.66 |

* One ECG of schizophrenic patient with missing PR value.

Results

Thirty patients were hospitalized for bipolar relapse (mania, depression, and mixed states), and 31 were admitted for acute exacerbation of schizophrenia. An additional 11 bipolar and 7 schizophrenic subjects had abnormal ECGs and were not included in the analysis of ECG parameters. Among bipolar individuals with normal ECGs, 20 (66.7%) were men and 10 (33.3%) were women. All schizophrenic cases with normal ECGs, with the exception of one, were men. Mean age among bipolar individuals was $41.7 \pm \text{SEM } 2.3$ (standard error of the mean), and among schizophrenic subjects it was 37.5 ± 1.5 years ($p = 0.14$).

Seven (21.9%) bipolar persons had been receiving lithium for more than 3 days or had a level greater than 0.3 mEq/L (cut off chosen because this level is not therapeutic); none of the schizophrenic individuals were on lithium. Three (9.4%) bipolar subjects were prescribed as neuroleptic, and only 8 (25%) of the schizophrenic patients were on neuroleptic medications. Thus, a majority of the cases were unmedicated because the ECG was usually recorded on the day of admission.

Women were overrepresented in both the bipolar group (33.3%) vs 0.3% of schizophrenics) and among lithium-treated patients (71% of people receiving lithium). Bipolar women tended to be older than bipolar men ($45.5 \pm \text{SEM } 3.9$ vs 38.0 ± 1.6 years, $p = 0.06$); had a significantly faster heart rate (90.6 ± 5.4 vs 77.5 ± 1.9 bpm, $p = 0.007$); a significantly briefer QRS (78.3 ± 2.9 vs 87.2 ± 1.1 m sec, $p = 0.0012$); and a significantly longer QTC (416.0 ± 7.0 vs 399.1 ± 3.2 m sec, $p = 0.03$).

Schizophrenic subjects were more likely than bipolar subjects to exhibit high QRS voltage (Table 1). There were no other outstanding patterns of abnormalities among ECGs of either schizophrenics or bipolars.

Discussion

No diagnosis-specific alteration in the duration of ECG intervals and waves among acutely relapsed bipolar and schizophrenic men were documented. The observation that the QRS duration may be briefer in bipolar individuals (Table 1) is probably related to the overrepresentation of females in the bipolar group. Women are known to have a shorter QRS duration.¹⁸⁻²²

If reported mood-state-related alterations of ion distribution and regulation affect the heart, they do not produce electrophysiologic changes that were detected by surface ECG. However, there are methodologic problems that may have limited this investigation. Paramount among these is that ion regulation abnormalities are most clearly seen between ill and recovered bipolar patients.^{13,23} We did not compare ill bipolar patients with euthymic individuals.

In our relatively young population of psychiatric patients, there was a sizeable number of significantly abnormal ECGs (Table 2). This was true of 26.8% of bipolar and 18.4% of schizophrenic subjects' ECGs ($p = 0.4$). While the major-

Table 2. ECG abnormalities among all bipolar (n = 40) and schizophrenic (n = 38) subjects. Note: ECGs many have multiple abnormalities.

| | Number of Bipolars Affected (%) | Number of Schizophrenics Affected (%) |
|-----------------------------------------|---------------------------------|---------------------------------------|
| Left Ventricular Hypertrophy by Voltage | 6 (14.6) | 6 (16.0) |
| High QRS Voltage | 0 | 5 (13.2) |
| Nonspecific ST-T Changes* | 6 (14.6) | 4 (10.6) |
| Conductive Delay | 2 (5) | 2 (5.3) |
| Right Atrial Enlargement | 3 (7.3) | 1 (2.6) |
| Right Axis Deviation | 1 (2.4) | 2 (5.3) |
| Left Atrial Enlargement | 1 (2.4) | 0 |
| Q Waves (of questionable significance) | 1 (2.4) | 1 (2.6) |

* Two bipolar, and 2 schizophrenic subjects not on lithium.

ity of these abnormalities are benign, the possibility of cardiovascular comorbidity remains. A prospective study of cardiovascular comorbidity in bipolar illness and schizophrenia and its implications would seem to be indicated.

References

1. Greenspan J, Schildraut JJ, Gordon EK, et al. Catecholamine metabolism in affective disorders. III. e-methoxy-4-hydroxyphenylglycol and other catecholamine metabolites in patients treated with lithium carbonate. *J Psychiatr Res.* 1970;7:171-183.
2. Bond PA, Jenner FA, Sampson GA. Daily variations of the urine content of MHPG in two manic-depressive patients. *Psychol Med.* 1972;2:81-85.
3. Jones F del, Maas JW, Dekirmenjian H, et al. Urinary catecholamine metabolites during behavioral changes in a patient with manic-depressive cycles. *Sciences.* 1973;179:300-302.
4. Rutledge CO, Honason J. Metabolic pathways of dopamine and norepinephrine in rabbit brain in vitro. *J Pharmacol Exp Therap.* 1967;157:493-502.
5. Maas JW, Landis DH. In vivo studies of the metabolism of norepinephrine in the central nervous system. *J Pharmacol Exp Therap.* 1968;163:147-162.
6. Dubovsky SL, Christiano J, Daniell LC, et al. Increased platelet intracellular calcium concentration in patients with bipolar affective disorders. *Arch Gen Psychiatry.* 1989;46:632-638.
7. Dubovsky SL, Lee C, Christiano J, Murphy J. Elevated platelet intracellular concentration in bipolar depression. *Biol Psychiatry.* 1991;29:441-450.
8. Dubovsky SL, Murphy J, Thomas M, Rademacher J. Abnormal intracellular calcium ion concentration in platelets and lymphocytes of bipolar patients. *Am J Psychiatry.* 1992;149:118-120.
9. Melnikova TS, Beliaev BS, Larovaia AB. (Dynamics of ECG changes during the treatment of depressive conditions with different variants in the course of endogenous affective psychosis) (Russian, English Abstract). *2h Nervopatol Psikihiatr.* 1992;92:92-95.
10. Lippmann S, Manshadi M, Wagemaker H, Baldwin H. Using pulse rate to assess the severity of psychosis. *Hosp Commun Psychiatry.* 1983;34:739-741.
11. Rose SP, Bone S, Haidorfer C, Dunner DL, Fieve RR. Lithium treatment in older patients. *Am J Psychiatry.* 1982;43:47-51.
12. Naylor GJ, Smith AHW, Dick EG, et al. Erythrocyte membrane cation carrier in manic-depressive psychosis. *Psychol Med.* 1980;10:521-525.
13. El-Mallakh RS, Barrett JL, Wyatt RJ. The Na,K-ATPase hypothesis for bipolar disorder: Implications of normal developments. *J Child Adolesc Psychopharmacol.* 1993;3:37-52.
14. Choi SJ, Taylor MA, Abrams R. Depression, ECT, and erythrocyte adenosine triphosphatase activity. *Biol Psychiatry.* 1977;12:75-81.
15. Coppen A, Shaw DM, Maleson A, Costair R. Mineral metabolism in mania. *Br Med J.* 1966;1:71-75.
16. Dubovsky SL, Franks RD. Intracellular calcium ions in affective disorders. A review and an hypothesis. *Biol Psychiatry.* 1983;18:781-797.
17. Meltzer HL. Is there a specific membrane defect in bipolar disorder? *Biol Psychiatry.* 1991;30:1071-1074.
18. Hafkesbring EM, Drawe CE, Ashman R. Children's electrocardiograms. I. Measurement for one hundred normal children. *Am J Dis Child.* 1937;53:1457-1469.
19. Larsen K, Skulason T. The normal electrocardiogram. I. Analysis of the extremity derivations from 100 normal persons whose ages ranged from 30 to 50 years. *Am Heart J.* 1941;22:625-644.
20. Simonson E, Blackburn H, Puchner TC, Eisenberg P, Ribeiro F, Meja M. Sex differences in the electrocardiogram. *Circulation.* 1960;22:598-601.
21. Chen C-Y, Chiang BN, Macfarlane PW. Normal limits of the electrocardiogram in a Chinese population. *J Electrocardiol.* 1989;22:1-15.
22. Storstein L, Bjornstad H, Hals O, Mee HD. Electrocardiographic findings according to sex in athletes and controls. *Cardiol.* 1991;79:227-236.

Everybody Out of the Pool!

I dunno, maybe the caption should be "everybody into the pool!" What with joint ventures, amalgamations, unions, take overs, and bonding, the individual patient and lone doctor seem to slip out of the mainstream. The days of individuality are fast disappearing or maybe even gone.

To buy a tailor-made suit on Saville Row or even at Brooks Brothers would require multiple encounters between vendor and customer. To compare this analogy to current medical care, it is nearer to "one size fits all" than anything else.

As business people, corporate giants, and the government take over the multi-billion dollar medical care morass, the bottom line becomes profit. Now profit is not a bad word; it allows one to stay in business. I have made a profit each and every year I have been in practice, so there is no finger pointing here. But there the comparison ends.

When my phone rings — at office or home — and it is a patient calling, they get me. I want no buffer to protect me from that person's needs. When the patient and I talk either in person or by phone, there is no clock ticking nor meter running, and that is the easy part of medical care. It becomes difficult and laborious when my decision requires testing and laboratory help. Then the wicket really gets sticky. I have to talk to a third person to authorize my requests for said testing.

This person I talk to has a sole purpose to mind the coffer and avoid unnecessary expenditure of the pool of money, so as not to lower the profit level. That's where the rubber hits the road.

I'm not saying every test I do carries with it a diagnostic gem and a wealth of positive information. Often as not the results are normal. But that information too is important to patient care.

As I reflect over the past, neither patient nor disease have changed; they remain pretty much the same. The patient still appreciates the availability of a caring doctor and is generally satisfied with the delivery of that care. Disease has changed but little, with the exception of AIDS and genetic-related conditions.

But what has changed dramatically has been the art of diagnosis and the magic of therapy. Also out there, the patient knows what is available in both spheres of diagnosis and of therapy. How many times have I heard the story of "Doctor I've had this headache now for three days, don't I need a MRI?"

If the patients bear no burden of the cost of these procedures, then they feel why not "go for it." The same applies to requests for admission of a family member to a hospital to allow a window of relief of burden for that care at home. Say nothing about the 90-year-old nursing home patient who is a stated "no code" being sent to an emergency room for "evaluation." Somehow it seems more acceptable to expire in a medical facility rather than home or nursing home.

So it seems to mean little whether we are in the pool or out of the pool, medical delivery systems move inexorably to change for the worse. As time goes by the patient will learn to accept the care they receive because they will have

"As business people, corporate giants, and the government take over the multi-billion dollar medical care morass, the bottom line becomes profit."

nothing with which to compare it. And the doctors will but remember the golden years when judgments and decisions were made by the patient-physician team and not be an insurance bureaucrat denying service or a cut-rate pharmacy in Texas insisting upon a generic equivalent.

The bottom line seems to count the most at the top.

Milton F. Miller, MD



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Ripples in a Pond

The Impact of What We Do Expands beyond Our Imaginations

Kentucky artist, Carolyn B. (Mrs Gil) Daley is the talented Kentucky Medical Association Alliance Vice-President for AMA-ERF. One of her fund-raising efforts is featured in this article, all-occasion greeting cards reproduced from four of her original watercolors. A generous donor has underwritten the entire cost of this project; therefore all proceeds from the sale of these cards go to the American Medical Association Education and Research Foundation.

The prime factor responsible for the high standard of medical care in the United States is the expertise of the physicians who provide it. To maintain excellence in patient care, physicians must have access to quality medical training. As the cost of medical education continues to increase and sources of funding dwindle, support from the medical community is vital to ensuring that future physicians receive the best educational and research opportunities possible.



Carolyn Daley is the talented artist whose original work was recreated on the all-occasion greeting cards pictured on the following page.

Realizing the financial difficulties facing medical schools and students, the AMA Board of Trustees established the AMA-ERF in 1950. Since that time, over \$65 million has been contributed to medical schools throughout the United States.

Your contribution will be sent to the medical school of your choice and used in the fund of your choice: the unrestricted Medical School Excellence Fund or the Medical Student Assistance Fund.

If you choose to honor someone via your contribution to AMA-ERF, the individual or family will be notified of the gift.

Robert E. McAfee, MD, as President of the American Medical Association, stated: "Just as when you throw a pebble into a pond, the ripples expand beyond our sight, so the impact of what each of us does can expand beyond our imagination."

This is at the heart of what the medical family is all about: giving freely of our strengths, knowledge, and resources, providing an enduring



Ruth Ryan

legacy for our physicians of tomorrow.

This past year, the AMA Alliance, nationwide, was responsible for raising almost \$1.4 million for AMA-ERF. That was achieved by Alliance "ambassadors" who comprise the volunteer support network that enables the AMA-ERF to reach out to donors within the medical community. Please help us continue this partnership with our physician spouses.

Ruth Ryan
KMAA President

Please make a check payable to AMA-ERF, send with this form to Carolyn B. Daley, KMA Alliance Vice-President for AMA-ERF, 118 Campbell Drive, Apt 102, Hazard, KY 41701.

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(Please turn the page for greeting cards order form.)



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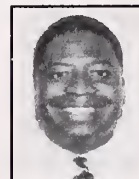
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146th KMA Annual Meeting



Clockwise from top left: Outgoing President Danny M. Clark, MD, and wife Joyce enjoyed the KEMPAC banquet; President-Elect C. Kenneth Peters, MD, was escorted to the podium by Past Presidents Robert R. Goodin, MD (L), and Bob M. DeWeese, MD; DSA Honoree John P. Stewart, MD, a retired Frankfort radiologist, and his wife are pictured with their daughter-in-law and son, Drs Magdalene Karon and John D. Stewart, II; newly elected President Mitchell is congratulated by his friend and mentor, Hiram C. Polk, MD; President-Elect Peters' wife, Rhoda, was escorted to the podium by Past AMA and KMA President Hoyt D. Gardner, MD.



Annual Meeting



Clockwise from top left: President William H. Mitchell, MD, and his wife Winnie relaxed at the KEMPAC Banquet; Robert G. Cox, soon-to-retire Executive VP of KMA, congratulated newly inaugurated President Mitchell, the last president to be installed during his 35-year tenure; Board Chair Harry W. Carlross, MD, administered the Presidential Oath of Office to Dr Mitchell; KMA's Lay Person Award honoree Carolyn Kurz, Executive Director of the Fayette County Medical Society, shared the happy occasion with John R. White, MD (L), immediate Past President of the FCMS, and Daniel E. Kenady, MD, current FCMS President.



KMA's 146th President, William H. Mitchell, MD, stood humbly as the President's Luncheon crowd gave him a standing ovation during his inauguration.

Inauguration

William H. Mitchell, MD, a Richmond surgeon, was inaugurated 1996-97 President of KMA at the 146th Annual Meeting held in Louisville, September 25-28. A graduate of the University of Kentucky College of Medicine, Dr Mitchell began his service to KMA in 1981 as 11th District Alternate Trustee, followed by Trustee, Vice-President, and President-Elect. During 1992-93 he served simultaneously as President of the Madison County Medical Society, the Kentucky Chapter of the American College of Surgeons, and the Hiram C. Polk Surgical Society. Dr Mitchell chairs the PRO Advisory Committee and is a member of the Scientific Program, Physician Workforce, Legislative Quick Action, Professional Liability Insurance, and Public Education Committees.

Board of Trustees — Elections

The KMA Board of Trustees held its reorganizational meeting for the 1996-97 Association year on September 29, 1996. Board Chair Harry W. Carloss, MD, introduced the newly elected members of the Board and the new officers. C. Kenneth Peters, MD, Louisville, was elected President-Elect; Donald R. Stephens, MD, Cynthiana, was reelected Vice President. John W. McClellan, Jr, MD, Henderson, was elected Speaker, House of Delegates; Thomas K. Slabaugh, MD, Lexington, was elected Vice Speaker. Newly elected Trustees were Daniel W. Varga, MD, Louisville, 5th District; John T. Burch, MD, Bowling Green, 6th District; Thomas E. Bunnell, MD, Erlanger, 8th District; Richard A. Stone, MD, Richmond, 11th District; Donald E. Brown, MD, Somerset, 12th District; and Meredith J. Evans, MD, Middlesboro, 15th District.

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice



The University of Kentucky Medical School class of 1970 graduated three physicians destined to become Kentucky Medical Association Presidents — Drs Ardis D. Hoven, William H. Mitchell, and Preston P. Nunnelley.

President, and Secretary-Treasurer for the 1996-97 KMA year. Harry W. Carloss, MD, Paducah, was reelected Chair, Board of Trustees, and Donald R. Neel, MD, Owensboro, was elected Vice Chair. Kenneth R. Hauswald, MD, Ashland, and J. Gregory Cooper, MD, Cynthiana, were named as Trustees-at-large.

The next meeting of the Board was scheduled for December 18-19, 1996.

Five physicians were elected by the House of Delegates to serve on the 1997 Nominating Committee. Members elected were:

P. Bruce Barton, MD
Corbin, Chair

John W. Collins, MD
Lexington

Kathleen C. Harter, MD
Louisville

Rebecca D. Shadowen, MD
Bowling Green

David J. Zoeller, MD
Elizabethtown

President's Luncheon

The President's Luncheon guests honored outgoing President Danny M. Clark, MD, and witnessed the installation of William H. Mitchell, MD, as the 146th President of KMA.

In his Inaugural Address, Dr Mitchell focused on the dramatic changes that influence the way physicians practice medicine today and how the actions, choices, and decisions made today will profoundly affect patients and the profession tomorrow. Notable comments included "As physicians we cannot permit ourselves to assume a passive role in the changes that face us. I need your support, your advice, your counsel, and your active involvement in these efforts. . . . If the term 'quality' is defined as: 'The most appropriate care, in the most appropriate setting, at the most appropriate time,' then I accept the definition. This means that



President Mitchell received the congratulations of KMA's newly appointed Executive Vice President Designate, William T. Applegate.



KEMPAC Chair William P. VonderHaar, MD, was accorded a Special Resolution and a standing ovation by the House of Delegates for two consecutive years of record-setting KEMPAC membership.

Kentucky's Lieutenant Governor, Steve Henry, MD, addressed the House of Delegates.



the 'value' of a service can be indexed by the quality of the service relative to its cost. But, 'quality' means efficient. It does not mean cheap! . . . It is not apathy that afflicts most physicians. It is simply a paralysis of action in the face of a complex set of fears and anxieties." Dr Mitchell's address is printed in its entirety in the October 1996 *Journal*.

DSA Award

Each year the Kentucky Medical Association presents the Association's highest award to a member who has served their community, their state, and their profession with honor.

The 1996 recipient of the Association's most prestigious honor, the Distinguished Service Award, was bestowed upon John P. Stewart, MD, a retired Frankfort radiologist. He was honored at the President's Luncheon not only for his contributions to the profession but also to his community.

Dr Stewart is a Past President of the Franklin County Medical Society; served as KMA Trustee from the 7th Trustee District; and was Chair of the KMA Board of Trustees in 1975. Following the medical tradition of his father and grandfather, both physicians, Dr Stewart was installed in 1977 as KMA President, 83 years after his grandfather served in that same position.

In her presentation of the award to Dr Stewart, Ardis D. Hoven, MD, Chair of the Awards Committee, included these comments:

"Perhaps Dr Stewart's greatest service to the profession was his intense interest in the political affairs of the Commonwealth of Kentucky. He is and has been a personal friend and confidant of most Governors and legislative leaders and has on numerous occasions provided an open door for KMA leadership to the inner sanctum of politics. He has served as Chair of both the KMA State Legislative Committee and the National Legislative Committee — one



Newly elected President Mitchell is pictured with, L to R, Secretary-Treasurer William P. VonderHaar, MD, President-Elect C. Kenneth Peters, MD, and Vice President Donald R. Stephens, MD.

of few physicians ever accorded that honor — an extremely difficult task I might say — by the KMA Board of Trustees. In addition, he was a member of the KEMPAC Board of Directors.

“Under his firm leadership as President of KMA in 1978, the KMA Board of Trustees forged the decision to form the Kentucky Medical Insurance Company. The formation of KMIC followed the effort by KMA to enact tort reform in 1976. While KMA was successful in obtaining support from the 1976 General Assembly which adopted model tort reform measures, the Kentucky Supreme Court later threw out the legislation ruling it unconstitutional. Our honoree was at the forefront of the liability crisis and numerous other issues and understood the necessity of physician involvement in politics. He was instrumental in a re-profiled and enhanced KMA legislative effort.

“The Distinguished Service recipient has served on numerous charitable boards and organizations. He is a former member of the Board of the Hospital Corporation of America. He and his wife Millie reside in Frankfort where he is the owner and operator of the Stewart Home School which has been in his family for many years. His son, John, is a surgeon in Lexington.

“It is my distinct pleasure to present this award to Dr Stewart.”

Lay Person Award

The KMA Award, which is awarded to a lay person who has made significant contributions to the medical community, was presented to Carolyn Kurz, Executive Vice President of the Fayette County Medical Society.

In her presentation of the award to Ms Kurz, Awards Chair Ardis Hoven, MD, noted the following:

“The recipient of the 1996 KMA Lay Person Award is highly respected by those of us in this room. She is



Board of Trustees Chair, Harry W. Carloss, MD, addressed the House of Delegates. Seated, L to R, House Speaker John W. McClellan, Jr, MD, Immediate Past President Clark, and President Mitchell.

well-known for her 25 years of outstanding service to the Fayette County Medical Society and its members — and is held in high regard for her unfailing commitment to excellence and unflagging support for the medical profession.

Our 1996 recipient, the Executive Vice President of the Fayette County Medical Society, began her career in 1971. At that time society membership numbered less than 350 and she and a secretary constituted the entire staff.

“During the past 25 years, under her professional guidance, the Fayette County Medical Society has developed into a full-service professional organization. Its membership has tripled to more than 1,000, its budget increased tenfold, and its staff now equals six full-time

and ten part-time employees. In addition to expanding and making the organization highly visible within the community, she established a permanent headquarters, computerized the organization's operation, and developed a metro-wide answering/paging service which is used 24-hours daily by physicians and other health care professionals.

“Her foresight, unequaled fiscal prudence, and attention to budgetary matters has kept the Society on a solid financial foundation. All of this has been accomplished without a dues increase since 1983, which is truly a remarkable achievement in light of today's economy.

“While working quietly and efficiently in managing the Society's daily operation, she has been



Studying the resolutions before the House were Jefferson County Delegates, L to R, Susan M. Berberich, MD, Daniel W. Varga, MD, David H. Bizot, MD, Hobert L. Pence, MD, and James E. Redmon, Jr, MD. Richard M. Hench, MD, of Fayette County is standing behind Dr Varga.



Boyd County Delegates, L to R, Paul W. Craig, MD, Maurice J. Oakley, MD, Susan Prasher, MD, and Charles Watson, MD, closely monitored the proceedings of the House of Delegates.

extremely effective in representing physicians' interests in the community.

"She has served on various committees of local and state organizations including the Better Business Bureau, Chamber of Commerce, Rotary, Altrusa Club of Lexington, Midway College's Business Administration Advisory Council, KET, the Cystic Fibrosis Foundation of Kentucky, the Kentucky Woman's Conference, and the steering

committee of UK's Small Business Development Center's annual "Women Mean Business" statewide conference. In 1994, our honoree was named by *The Lane Report* one of the top women in business and is a member of *Who's Who of American Women*. She is a member of the Rotary Club, American Association of Medical Society Executives, and the Kentucky Society of Association Executives.

"Having established excellent

working relationships with the professional staffs of the Kentucky Medical Association and the American Medical Association, she provides an important link between the Society's members and their peers on state and national levels.

"Professionally, she has earned the distinction of Certified Association Executive from the American Society of Association Executives, a distinction earned by only 12% of the 16,000 members. In 1992, when she earned her certifications, she was the only Kentuckian to be so honored.

"Our 1996 recipient is a credit to her community and to the medical profession. She exemplifies high moral and professional standards for herself, her staff, the Society, and the community."

Educational Achievement Award

The recipient of the 1996 KMA Educational Achievement Award was Ward O. Griffen, MD, a professor of surgery at the University of Kentucky Medical Center. Dr Griffen also served as the Executive Director and Secretary-Treasurer of the American Board of Surgery from 1984-94.

Dr Griffen's life and career have been dedicated to teaching students and residents not only about surgery, but also "how to be a doctor." He has consistently been outspoken on educational issues that concern students and residents.

He has had many special honors including The Good Physician Award at Cornell University Medical College in 1952; the Minnesota Surgical Alumnus of the Year in 1984; and the Ward O. Griffen Endowed Chair in Surgery established at the University of Kentucky College of Medicine in 1991.

Dr Griffen is Board Certified in both general surgery and thoracic surgery. His professional involvement includes service on the surgical committee of the National Board of Medical Examiners in 1973 and

Chairman of that committee from 1977-1979. In addition, he served as an Examiner for the American Board of Surgery from 1974-1977, and a Director of that organization from 1977-1983.

In one of the numerous letters of support received for Dr Griffen, a description of the Society of Hillbilly Surgeons was given, which was developed to honor Dr Griffen and the principles he endorsed. The inscription of the founding of the organization reads as follows:

"The Society founded in 1978 is dedicated to the recognition and preservation of the values and the characteristics which should exemplify the gentleman, physician, and surgeon. The Society holds as a guiding principle that we must recognize the things we are not, without feeling embarrassed about who or what we are. We reaffirm that the virtues of honesty and honor, conscience and humility, and compassion and integrity are paramount in professional as well as private endeavors."

Scientific Exhibit Award

Several excellent Scientific Exhibits were displayed at the 146th KMA Annual Meeting. The award winner was an outstanding exhibit by John J. Guarnaschelli, MD; David A. Petruska, MD; Wayne G. Villanueva, MD; A. J. Dzenitis, MD; S. Stawicki, BS, entitled "Surgery for Cervical Disc Disease: A Retrospective Data-Base of 2000 Patients."

Alliance AMA-ERF

During the first meeting of the House of Delegates, Marla Vieillard, KMAA Past President, presented AMA-ERF checks to the two medical schools on behalf of the Alliance. Since 1950, the AMA-ERF has continually been supportive of quality medical education, with contributions now exceeding \$2 million annually. The

extraordinary fund raising efforts of the AMA Alliance and the generosity of contributing medical families and private enterprise continue to secure AMA-ERF as a viable support for medical education.

In Kentucky, AMA-ERF funds are given proportionally to the two medical schools as designated by the donors. Alfred L. Thompson, MD, Associate Vice President for Health Affairs (Vice Dean for Clinical Affairs) at the University of Louisville School of Medicine, accepted a check from



Top, Emery A. Wilson, MD, Dean of the University of Kentucky College of Medicine, expressed his thanks for the Alliance's AMA-ERF check. Left, KMAA Immediate Past President Marla Vieillard presented an AMA-ERF check to Alfred L. Thompson, MD, Associate Vice President for Health Affairs, University of Louisville School of Medicine.



Mrs Vieillard for \$20,115.56, and Emery A. Wilson, MD, Dean of the University of Kentucky College of Medicine, accepted a check for \$14,376.00.

Fifty-Year Members

Those KMA member physicians who have been practicing medicine for 50 years or more were recognized during the President's Luncheon. Achieving that status this year are: Drs W. Lloyd Adams, Mehmet S. Akaydin, Frank E. App, McHenry S. Brewer, Bourbon E.

Canfield, Ballard W. Cassady, C. Louise Caudill, Walter L. Cawood, Vinoobhai M. Cholera, Kenneth P. Crawford, Stanley J. Cyran, Russell H. Davis, Clarence E. Denton, Francis A. Forde, Harold F. Funke, William R. Gabbert, Albert G. Goldin, William R. Gray, Robert A. Hall, Robert W. Hamm, Mervel V. Hanes, Douglas M. Haynes, John A. Hemmer, Walter R. Johnson, Conrad H. Jones, James J. Kelly, Harold E. Kleinert, Robert W. Lykins, Daniel E. Mahaffey, J. Herman Mahaffey, Charles K. Mahaffey, W. Porter Mayo, G. David McClure,



L to R: State Representative Richard L. Murgatroyd and guest, Villa Hills; KMA's newly elected 8th District Trustee Thomas E. Bunnell, MD, Erlanger; AMA Alternate Delegate William B. Monnig, MD, Edgewood.



State Representative Bob M. DeWeese, MD, and his wife Angie.



L to R: State Senator Tom Buford, Nicholasville; KEMPAC Vice Chair Robert D. Woods, MD, Lexington; KMA Past President and KEMPAC Treasurer Preston P. Nunnelle, MD, and his wife Lucille, Lexington.



KEMPAC Chair William P. VonderHaar, MD, Louisville, was the recipient of two AMPAC Membership awards. AMPAC Board member Thomas C. Payne, MD, of East Lansing, Michigan, made the presentation.



National Legislative Chair Donald C. Barton, MD, and his wife Sue (R), Corbin, were seated with Everett E. Bickers, MD, and his wife, of Floyds Knobs, Indiana.



P. John Seward, MD, EVP, American Medical Association, was the featured speaker for the KEMPAC Banquet.



Robert G. Cax, KMA Executive VP, and his wife Kay were seated with AMPAC Board member Thomas Payne, MD (R).



L to R: Senator Crase's wife Jan; Senate Minority Leader Dan Kelly; Senator Jim Crase, MD, Somerset; Chief Administrative Assistant to Senate Republicans Becky Harrelson; Senator Tam Bufard (standing).

KEMPAC

A distinguished group of state leaders, KMA members, and their spouses attended the KEMPAC Seminar Banquet held during the KMA Annual Meeting. AMA Executive Vice President P. John Seward, MD, addressed the group, and KEMPAC Chair William P. Vonderhaar, MD, presided at the meeting. Several in attendance are recognized in this spread of photos.



L to R: KMA President William H. Mitchell, MD, Richmond; Lieutenant Governor Steve Henry, MD; KEMPAC Chair William P. Vanderhaar, MD.



L to R: AMA Delegate and KMA Past President Robert R. Gaadin, MD, and his wife Carol, Louisville; AMA Delegate and State Legislative Chair Wally O. Mantgamery, Paducah.



KMA Executive Vice President Designate William T. Applegate (L) was seated with Indiana State Medical Association President Jerame Melchiar, MD, and his wife Martha.



Delegates Uday V. Dave, MD, (L) and Iyad A. Al-Jabi, MD, both of Madisonville, discussed the issues during a break in house action.



All three floor microphones received frequent use as Delegates addressed the Resolutions before the House.

George G. McKinley, Howard B. McWhorter, A. Reeves Morgan, George R. Nichols, Maurice A. Perellis, John D. Redden, William T. Ramage, Holmes G. Sargent, Bernard J. Schoo, John J. Schwab, Robert L. Shuffett, Paul J. Sides, Thomas G. Stigall, C. Maximilian Talbott, George R. Tanner, Robert S. Tillett, Louis F. Vieillard, Walter M. Wolfe.

In Memoriam

During the first House of Delegates meeting, Secretary-Treasurer William P. VonderHaar, MD, requested that the audience stand for a moment of

silence in memory of those physician members who had died in the last year. A list of the deceased appears on page 525 of this *Journal*.

KMA-MSS and RPS

The 1996 joint Annual Meeting of the KMA Medical Student Section and Resident Physician Section, held September 27, dealt with "Politics and the Medical Profession." Kentucky State Senator James D. Crase, MD,

A large audience of physicians, spouses, Kentucky State Representatives, Senators, and their staff heard feature presentations by P. John Seward, MD, EVP, American Medical Association, and Thomas C. Payne, MD, of East Lansing, Michigan, a member of the AMPAC Board. KEMPAC Chair, William P. VonderHaar, MD, Louisville, presided at the meeting.

House Action Summary

The Association's policymaking body, the House of Delegates, met on September 26 and again on September 28 to consider issues including participation in organized medicine, managed care, Medicaid, and other medical issues.

Highlights of House actions are listed below. Please refer to the House of Delegates section in this *Journal* for a complete text of the Committee Reports and Resolutions.

- Urged physicians in all medical groups, managed care organizations, and academic institutions to join and participate in organized medicine in order to preserve a unified and broad-based voice that focuses on patient advocacy and physician/patient priorities in health care.
- Encouraged corporate health care entities and their directors to financially support and underwrite membership in all levels of organized medicine.
- Directed that KMA work with the Kentucky Department of Education to develop a set of forms for school examinations and student athletic examinations that will be considered an acceptable alternative in all Kentucky school districts and discourage the use of multiple forms.
- Recommended that KMA provide information about the Commission on Office Laboratory Accreditation and encourage physicians to seek

and Lieutenant Governor Stephen L. Henry, MD, gave students and residents an overview of what is going on in Frankfort that will affect their future practices.

Immediate Past Chair of the AMA-MSS Governing Council, James Woody, MD, UK family practice resident, gave a report on activities taking place at the national level.

KEMPAC

The 34th KEMPAC Seminar Banquet was held during this year's Annual Meeting on Thursday, September 26, at the Hyatt Regency Hotel, Louisville.



Many of the General Scientific Sessions had SRO attendance. Here, a packed crowd heard Dr Hiram Polk, a University of Louisville surgeon, speak on "To What Extent is the Specialist an Answer to the Generalist Shortage?"

laboratory accreditation through COLA.

- Opposed reallocation of human, financial, and academic resources currently available for medical education toward an additional allopathic, osteopathic, public or private medical school.
- Commended physician public servants Lt. Governor Stephen L. Henry, MD; Senator Nick Kafoglis, MD; Senator James D. Crase, MD; Representative Bob M. DeWeese, MD; and Representative Ernest Fletcher, MD, for giving so unselfishly to their community, state, and profession.
- Directed that KMA maintain as a principle that whenever possible in the negotiation of contracts for health care services, physicians in all regions in Kentucky be compensated equally for services.
- Directed that KMA develop or adopt, in consultation with physicians and other appropriate organizations, guidelines for the prescribing and utilization of

nursing home services, home health services, and rehabilitation services.

- Recommended HIV testing of all pregnant women and communicating this same recommendation to all providers of prenatal and obstetrical care.
- Supported the Commodity Growers Cooperative Association and its new affiliate organization, the Partners for Family Farms.
- Continued its endorsement of the KPC goal of increasing access to care for Kentucky's less fortunate citizens.
- Encouraged physicians to have discussions on the local level with their health department and hospitals to help better define what the future role of health departments is in the commonwealth.
- Directed that Subcommittee on Domestic Violence survey results be made known to all Kentucky physicians.
- Recommended a three-hour training course on domestic

violence be developed for primary care physicians in Kentucky.

- Encouraged members to become familiar with electronic data interchange and remain aware of ongoing technological advances.

Attendance

This year's KMA meeting, the first with a Thursday-Saturday schedule, attracted a crowd of 2,072. Physicians numbered 1105 and medical students 129, resulting in a very successful 146th KMA Annual Meeting at the Hyatt Regency Hotel/Commonwealth Convention Center in Louisville. The 1997 Annual Meeting will also be held in Louisville. The Board of Trustees has again selected the very accommodating and spacious Hyatt Regency Hotel/Commonwealth Convention Center to house the meeting. Over 22 specialty groups and an estimated 2600 registrants are expected to attend.

Please mark your calendars to attend the 1997 KMA Annual Meeting to be held in September.

ROLL CALL

1996 House of Delegates

1st Meeting September 26, 1996

2nd Meeting September 28, 1996

OFFICERS

| | | First Meeting | Second Meeting |
|---------------------------|---------------------------|---------------|----------------|
| Speaker | C. Kenneth Peters, MD | Present | Present |
| Vice Speaker | Jahn W. McClellan, Jr, MD | Present | Present |
| President | Danny M. Clark, MD | Present | Present |
| President-Elect | William H. Mitchell, MD | Present | Present |
| Vice-President | Danald R. Stephens, MD | Present | Present |
| Secretary-Treasurer | William P. VanderHaar, MD | Present | Present |
| AMA Delegate | Danald C. Barton, MD | Present | Present |
| AMA Delegate | Wally O. Mantgamery, MD | Present | Present |
| AMA Delegate | Robert R. Goodin, MD | Present | Present |
| AMA Delegate | Ardis D. Haven, MD | Present | Present |
| AMA Delegate | Danald J. Swikert, MD | Present | Present |
| AMA Alternate Delegate .. | Bob M. DeWeese, MD | Present | Present |
| AMA Alternate Delegate .. | J. Gregory Cooper, MD | Present | Present |
| AMA Alternate Delegate .. | Prestan P. Nunnelley, MD | Present | Present |
| AMA Alternate Delegate .. | William B. Mannig, MD | Present | Present |
| AMA Alternate Delegate .. | Baretta R. Casey, MD | Present | Present |

TRUSTEES

| District | | | |
|------------------|--------------------------|---------|---------|
| First | Harry W. Corloss, MD | Present | Present |
| Second | Danald R. Neel, MD | Present | Present |
| Third | C. R. Dodds, MD | Present | Present |
| Fourth | Eugene H. Shively, MD | Present | Present |
| Fifth | Joseph E. Kutz, MD | Present | Present |
| Sixth | J. Michael Pulliam, MD | Present | Present |
| Seventh | Ronald E. Walldridge, MD | Present | Present |
| Eighth | Mark F. Pelstring, MD | Present | Present |
| Ninth | J. Gregory Caaper, MD | Present | Present |
| Tenth | Russell L. Travis, MD | Present | Present |
| Eleventh | G. Irene Minar, MD | Present | Present |
| Twelfth | Scott B. Scutchfield, MD | Present | Present |
| Thirteenth | Kenneth R. Hauswald, MD | Present | Present |
| Fourteenth | E. D. Roberts, MD | Present | Present |
| Fifteenth | Paul R. Smith, MD | Present | Present |

ALTERNATE TRUSTEES

| District | | | |
|------------------|---------------------------|---------|---------|
| First | Robert C. Hughes, MD | Present | Present |
| Second | Joseph H. Harpole, Jr, MD | Present | Present |
| Third | Uday V. Dave, MD | Present | Present |
| Fourth | Brian F. Wells, MD | Present | Present |
| Fifth | Daniel W. Varga, MD | Present | Present |
| Sixth | Jahn T. Burch, II, MD | Present | Present |
| Seventh | Jahn M. Patterson, MD | Present | Present |
| Eighth | Jahn D. Amman, MD | Present | Present |
| Ninth | Robert L. McKenney, MD | Present | Present |
| Tenth | Andrew R. Pulita, MD | Present | Present |
| Eleventh | Richard A. Stane, MD | Present | Present |
| Twelfth | Danald E. Brawn, MD | Present | Present |
| Thirteenth | Susan H. Prasher, MD | Present | Present |
| Fourteenth | Baretta R. Casey, MD | Present | Present |
| Fifteenth | Roger A. Acosta, MD | Present | Present |

PAST PRESIDENTS

| | | | |
|----------------------|--------------------------|---------|---------|
| Past President | Robert R. Goodin, MD | Present | Present |
| Past President | Ardis D. Haven, MD | Present | Present |
| Past President | William B. Mannig, MD | Present | Present |
| Past President | S. Randolph Scheen, MD | Present | Present |
| Past President | Prestan P. Nunnelley, MD | Present | Present |

DELEGATES FIRST DISTRICT

| | | First Meeting | Second Meeting |
|------------------|-----------------------------------|---------------|----------------|
| BALLARD | Martha C. Robinson, MD, Barlaw | Present | Present |
| CALLOWAY | Robert C. Hughes, MD, Murray | Present | Present |
| | Rob T. Williams, MD, Murray | Present | Present |
| CARLISLE | | Present | Present |
| FULTON | William A. Smith, Jr, MD, Fulton | Present | Present |
| GRAVES | Charles E. Bea, MD, Mayfield | Present | Present |
| | Patricia S. Elliott, MD, Moyfield | Present | Present |
| HICKMAN | Bruce C. Smith, MD, Clinton | Present | Present |
| LIVINGSTON | Stephen Burkhart, MD, Salem | Present | Present |
| MARSHALL | | Present | Present |
| MCCRACKEN | Jahn E. Grubbs, MD, Paducah | Present | Present |
| | Kurt Klauburg, DO, Paducah | Present | Present |
| | Peter E. Lacken, MD, Paducah | Present | Present |
| | Brodley T. Ronkin, MD, Paducah | Present | Present |
| | Narma T. Rankin, MD, Paducah | Present | Present |
| | Charles B. Rass, MD, Paducah | Present | Present |
| | Caralyn S. Watson, MD, Paducah | Present | Present |

SECOND DISTRICT

| | | | |
|-----------------|----------------------------------------|---------|---------|
| DAVIES | Christapher J. Havelda, MD, Owensboro | Present | Present |
| | Robert H. Schell, MD, Owensboro | Present | Present |
| | J D Laucks, MD, Owensboro | Present | Present |
| | R. Wathen Medley, Jr, MD, Owensboro | Present | Present |
| | Marilyn Sonders, MD, Owensboro | Present | Present |
| | Terry Tyler, MD, Owensboro | Present | Present |
| | William Tyler, MD, Owensboro | Present | Present |
| HANCOCK | | Present | Present |
| HENDERSON | Jahn S. Cave, MD, Henderson | Present | Present |
| | Marcia L. Cave, MD, Henderson | Present | Present |
| | Morshall G. Howell, III, MD, Henderson | Present | Present |
| MCLEAN | | Present | Present |
| OHIO | Eric A. Narswanthy, MD, Hartford | Present | Present |
| UNION | | Present | Present |
| WEBSTER | | Present | Present |

THIRD DISTRICT

| | | | |
|------------------|----------------------------------------|---------|---------|
| CALDWELL | | Present | Present |
| CHRISTIAN | Gary V. James, MD, Marian | Present | Present |
| CRITTENDEN | Iyad A. Al-Jabi, MD, Madisanville | Present | Present |
| HOPKINS | Wollice R. Alexander, MD, Madisonville | Present | Present |
| | James M. Donley, MD, Madisanville | Present | Present |
| | Uday V. Dave, MD, Madisanville | Present | Present |
| | Mahan Roa, MD, Madisanville | Present | Present |
| LYON | | Present | Present |
| MUHLBERG | James S. Brashear, MD, Central City | Present | Present |
| TODD | | Present | Present |
| TRIGG | | Present | Present |

FOURTH DISTRICT

| | | | |
|-----------------|-------------------------------------|---------|---------|
| BRECKINRIDGE .. | James G. Sills, MD, Hardinsburg | Present | Present |
| BULLITT | | Present | Present |
| GRAYSON | Art McLaughlin, MD, Leitchfield | Present | Present |
| GREEN | William L. Shuffett, MD, Greensburg | Present | Present |

| | | | | |
|---------------|------------------------------------------|-------|---------|---------|
| HARDIN..... | Scott Koopermon, MD, Elizabethtown | ..... | Present | Present |
| | Lucion Moremon, MD, Elizabethtown | ..... | Present | Present |
| | Jeffrey Richardson, MD, Elizabethtown | ..... | Present | Present |
| HART..... | David Zoeller, MD, Elizabethtown | ..... | Present | Present |
| LARUE..... | James P. Crews, MD, Cove City | ..... | ..... | ..... |
| MARION..... | Richard L. Litt, MD, Lebanon | ..... | ..... | ..... |
| MEADE..... | Raymond L. Mothis, DO, Brandenburg | ..... | ..... | ..... |
| NELSON..... | Deborah Mottingly, MD, Bordstown | ..... | Present | Present |
| TAYLOR..... | Eugene H. Shively, MD, Campbellsville | ..... | Present | Present |
| WASHINGTON... | Brion F. Wells, MD, Springfield | ..... | ..... | ..... |

FIFTH DISTRICT

| | | | | |
|----------------|-----------------------------------------------|-------|---------|---------|
| JEFFERSON..... | Edward C. Adler, MD, Louisville | ..... | ..... | ..... |
| | Dovid T. Allen, MD, Louisville | ..... | ..... | ..... |
| | Kenneth C. Anderson, MD, Louisville | ..... | Present | ..... |
| | George R. Aronoff, MD, Louisville | ..... | ..... | ..... |
| | Joseph C. Bonis, Jr, MD, Louisville | ..... | ..... | ..... |
| | Suson M. Berberich, MD, Prospect | ..... | Present | ..... |
| | S. J. Bertolone, Jr, MD, Louisville | ..... | ..... | ..... |
| | David H. Bizot, MD, Louisville | ..... | Present | ..... |
| | Koren Koye Bloom, MD, Louisville | ..... | ..... | ..... |
| | Suson G. Bornstein, MD, Louisville | ..... | Present | Present |
| | Robert J. Brewer, MD, Louisville | ..... | Present | ..... |
| | William C. Buschemeyer, Jr, MD, Louisville | ..... | ..... | ..... |
| | Peter C. Campbell, MD, Louisville | ..... | ..... | ..... |
| | E. Dean Canon, MD, Louisville | ..... | Present | ..... |
| | Keith Carter, MD, Louisville | ..... | ..... | ..... |
| | J. William Comer, MD, Louisville | ..... | ..... | ..... |
| | John H. Doyle, MD, Louisville | ..... | Present | Present |
| | Michael J. Edwards, MD, Louisville | ..... | ..... | ..... |
| | Rudy J. Ellis, Jr, MD, Louisville | ..... | Present | ..... |
| | Somuel G. Eubanks, Jr, MD, Louisville | ..... | Present | Present |
| | Morjorie R. Fitzgerald, MD, Louisville | ..... | ..... | ..... |
| | Gory L. Fuchs, MD, Louisville | ..... | ..... | ..... |
| | Katherine P. Garrison, MD, Louisville | ..... | Present | Present |
| | Lindo H. Gleis, MD, Louisville | ..... | Present | ..... |
| | Richard A. Gould, MD, Louisville | ..... | ..... | ..... |
| | Manuel Grimaldi, MD, Louisville | ..... | Present | ..... |
| | Horold D. Haller, MD, Louisville | ..... | ..... | Present |
| | Kathleen C. Horter, MD, Louisville | ..... | ..... | ..... |
| | B. Thomas Horter, Jr, MD, Louisville | ..... | ..... | ..... |
| | Joyne L. Hallonder, MD, Louisville | ..... | Present | Present |
| | Anno K. Huang, MD, Louisville | ..... | ..... | ..... |
| | John G. Hubbard, MD, Louisville | ..... | ..... | ..... |
| | Walter I. Hume, Jr, MD, Louisville | ..... | Present | ..... |
| | Borboro Sue Isaacs, MD, Louisville | ..... | Present | ..... |
| | Ellen M. Joyce, MD, Louisville | ..... | Present | ..... |
| | Morgie Roe Joyce, MD, Louisville | ..... | Present | Present |
| | Sheri A. Kolbfleisch, MD, Louisville | ..... | Present | Present |
| | Stephen S. Kirzinger, MD, Louisville | ..... | Present | Present |
| | A. O'toyo Lolude, MD, Louisville | ..... | ..... | ..... |
| | Julie Lee, MD, Louisville | ..... | Present | ..... |
| | Michael T. Macfarlane, MD, Louisville | ..... | Present | ..... |
| | James E. McKiernon, Jr, MD, Louisville | ..... | ..... | ..... |
| | Frank B. Miller, MD, Louisville | ..... | ..... | ..... |
| | Cothleen J. Morris, MD, Louisville | ..... | ..... | ..... |
| | Rolph C. Morris, MD, Louisville | ..... | ..... | ..... |
| | Catherine Newton, MD, Louisville | ..... | ..... | ..... |
| | Voughn W. Payne, MD, Louisville | ..... | ..... | ..... |
| | Robert L. Pence, MD, Louisville | ..... | Present | ..... |
| | Hugh R. Peterson, Jr, MD, Louisville | ..... | ..... | ..... |
| | Mark E. Petrik, MD, Louisville | ..... | Present | Present |
| | Patricio M. Purcell, MD, Louisville | ..... | ..... | ..... |
| | Steven J. Roible, MD, Louisville | ..... | ..... | ..... |
| | Bernard O. Rond, MD, Louisville | ..... | Present | ..... |

| | | | | |
|--|------------------------------------------|-------|---------|---------|
| | James E. Redmon, MD, Louisville | ..... | Present | Present |
| | K. Thomas Reichard, MD, Louisville | ..... | Present | Present |
| | William M. Rendo, MD, Louisville | ..... | ..... | ..... |
| | Borton Reutlinger, MD, Louisville | ..... | Present | ..... |
| | Alon I. Roth, MD, Louisville | ..... | ..... | ..... |
| | Melindo Rowe, MD, Louisville | ..... | ..... | Present |
| | Someul R. Scheen, III, MD, Louisville | ..... | ..... | ..... |
| | Edward L. Scofield, MD, Louisville | ..... | Present | Present |
| | Lynn T. Simon, MD, Louisville | ..... | ..... | ..... |
| | Judoh L. Skolnick, MD, Louisville | ..... | ..... | ..... |
| | Bernard L. Speevock, MD, Louisville | ..... | ..... | Present |
| | Alfred L. Thompson, MD, Louisville | ..... | Present | Present |
| | Brendo I. Townes, MD, Louisville | ..... | ..... | Present |
| | Stuart Urboch, MD, Louisville | ..... | ..... | Present |
| | Daniel W. Vorgo, MD, Louisville | ..... | Present | Present |
| | David Watkins, MD, Louisville | ..... | ..... | Present |
| | Somuel D. Weakley, MD, Louisville | ..... | Present | Present |
| | John J. Whitt, MD, Louisville | ..... | ..... | Present |
| | Russell A. Williams, MD, Louisville | ..... | ..... | ..... |
| | Lisa A. Willis-Frank, MD, Louisville | ..... | ..... | ..... |
| | James Anthony Wright, MD, Louisville | ..... | ..... | Present |
| | C. Milton Young, III, MD, Louisville | ..... | Present | ..... |

SIXTH DISTRICT

| | | | | |
|----------------|------------------------------------------|-------|---------|---------|
| ADAIR..... | Gory L. Portin, MD, Columbio | ..... | ..... | ..... |
| ALLEN..... | ..... | ..... | ..... | ..... |
| BARREN..... | Warren J. Eisenstein, MD, Glasgow | ..... | ..... | ..... |
| | Melisso Walton-Shirley, MD, Glasgow | ..... | ..... | ..... |
| BUTLER..... | Richard T. Won, MD, Morgantown | ..... | ..... | ..... |
| CUMBERLAND.... | Joseph D. Skipworth, MD, Burkesville | ..... | ..... | ..... |
| EDMONSON..... | Omkor N. Bhatt, MD, Brownsville | ..... | ..... | ..... |
| LOGAN..... | ..... | ..... | ..... | ..... |
| METCALFE..... | Lowrence P. Emberton, MD, Edmonton | ..... | ..... | ..... |
| MONROE..... | James E. Corter, MD, Tompkinsville | ..... | ..... | Present |
| SIMPSON..... | Michael Pulliom, MD, Franklin | ..... | Present | Present |
| WARREN..... | Mark E. Bigler, MD, Bowling Green | ..... | ..... | ..... |
| | John T. Burch, MD, Bowling Green | ..... | ..... | Present |
| | Robert J. Emslie, MD, Bowling Green | ..... | Present | Present |
| | Rebecca D. Shodown, MD, Bowling Green | ..... | ..... | ..... |

SEVENTH DISTRICT

| | | | | |
|---------------|-----------------------------------------|-------|---------|---------|
| ANDERSON..... | Kenneth E. Hines, MD, Lowrenceburg | ..... | ..... | ..... |
| CARROLL..... | Cecil D. Martin, MD, Corrollton | ..... | ..... | ..... |
| FRANKLIN..... | Joseph J. Dobner, MD, Frankfort | ..... | ..... | ..... |
| | Arbo L. Kenner MD, Frankfort | ..... | Present | Present |
| | John M. Patterson, MD, Frankfort | ..... | ..... | ..... |
| GALLATIN..... | Benjamin Kutnicki, MD, Worsow | ..... | Present | Present |
| GRANT..... | ..... | ..... | ..... | ..... |
| HENRY..... | ..... | ..... | ..... | ..... |
| OLDHAM..... | Horold F. Funke, MD, Pee wee Valley | ..... | Present | Present |
| OWEN..... | Jofor Mahmood, MD, Owenton | ..... | ..... | ..... |
| SHELBY..... | James R. Smith, MD, Shelbyville | ..... | ..... | ..... |
| | Ronald E. Waldridge, MD, Shelbyville | ..... | ..... | ..... |
| SPENCER..... | Thomas C. Croin, MD, Taylorsville | ..... | ..... | ..... |
| TRIMBLE..... | Carl Cooper, Jr, MD, Bedford | ..... | Present | Present |

EIGHTH DISTRICT

| | | | | |
|---------------|----------------------------------------------|-------|---------|---------|
| BOONE..... | Robert L. Boker, Jr, MD, Crescent Springs | ..... | Present | Present |
| | Neal J. Moser, MD, Burlington | ..... | ..... | Present |
| | Nancy C. Swikert, MD, Florence | ..... | Present | Present |
| | James A. Zollo, MD, Florence | ..... | Present | Present |
| CAMPBELL..... | James L. Evons, III, MD, Fort Thomas | ..... | ..... | ..... |

| | | | |
|--------------|-------------------------------------------|---------|---------|
| KENTON | Steven M. Waadruff, MD, Florence | ..... | ..... |
| | Gardan W. Air, MD, Crestview Hills | Present | Present |
| | Elbert D. Baldridge, Jr, MD, Covington | ..... | ..... |
| | Thomas E. Bunnell, MD, Erlanger | Present | Present |
| | Mark A. Cepela, MD, Edgewaad | ..... | ..... |
| | Joseph C. Martin, MD, Erlanger | ..... | Present |
| | Rass McHenry, MD, Covington | ..... | Present |
| | Theodore H. Miller, MD, Edgewaad | Present | ..... |
| | Richard E. Park, MD, Covington | ..... | Present |
| | B. Robert Schwartz, MD, Edgewaad | ..... | ..... |

NINTH DISTRICT

| | | | |
|-----------------|--------------------------------------|---------|---------|
| BATH ..... | ..... | ..... | ..... |
| BOURBON | Emmett Lee Tate, MD, Paris | ..... | Present |
| BRACKEN ..... | ..... | ..... | ..... |
| FLEMING | Glenn R. Wamack, MD, Flemingsburg | ..... | ..... |
| HARRISON | Danald R. Stephens, MD, Cynthiana | Present | Present |
| MASON | Leroy Shause, MD, Maysville | ..... | ..... |
| NICHOLAS | David W. Doty, MD, Maysville | Present | ..... |
| PENDLETON | Jase T. Larenza, MD, Carlisle | ..... | ..... |
| ROBERTSON | Robert L. McKenney, MD, Falmouth | Present | Present |
| SCOTT | Jahn M. Bennett, MD, Georgetawn | Present | ..... |

TENTH DISTRICT

| | | | |
|-----------------|--------------------------------------|---------|---------|
| FAYETTE | Keith T. Applegate, MD, Lexington | ..... | Present |
| | James W. Baker, MD, Lexington | Present | Present |
| | David J. Bensema, MD, Lexington | Present | ..... |
| | Kathleen J. Bas, MD, Lexington | Present | Present |
| | Terry David Clark, MD, Lexington | ..... | Present |
| | Jahn W. Collins, MD, Lexington | Present | Present |
| | Terry D. Clark, MD, Lexington | ..... | Present |
| | Jahn M. Fax MD, Lexington | ..... | Present |
| | Bill H. Harris, MD, Lexington | ..... | ..... |
| | Tamara James, MD, Lexington | ..... | ..... |
| | Raleigh O. Jones, MD, Nicholasville | ..... | ..... |
| | Magdalene B. Karan, MD, Lexington | Present | Present |
| | Dennis B. Kelly, MD, Lexington | ..... | Present |
| | Daniel E. Kenady, Sr, MD, Lexington | Present | Present |
| | Jahn M. Maare, MD, Lexington | ..... | Present |
| | William D. Newton, MD, Lexington | Present | Present |
| | William N. Offutt, IV, MD, Lexington | Present | ..... |
| | Gregory V. Osetinsky, MD, Lexington | ..... | ..... |
| | Charles L. Papp, MD, Nicholasville | ..... | Present |
| | Barbara A. Phillips, MD, Lexington | Present | Present |
| | Jahn W. Paundstone, MD, Lexington | Present | Present |
| | Nat H. Sandler, MD, Lexington | ..... | Present |
| | Glenn R. Sheorer, MD, Lexington | ..... | ..... |
| | Thomas K. Slabaugh, MD, Lexington | ..... | Present |
| | David B. Stevens, MD, Lexington | Present | ..... |
| | Jahn D. Stewart, MD, Lexington | Present | Present |
| | Jahn Robert White, MD, Lexington | Present | Present |
| | Emery A. Wilsan, MD, Lexington | Present | ..... |
| JESSAMINE ..... | ..... | ..... | ..... |
| WOODFORD | Narman S. Fisher, MD, Midway | ..... | ..... |

ELEVENTH DISTRICT

| | | | |
|------------------|----------------------------------------|---------|---------|
| CLARK | Daniel Alan Ewen, MD, Winchester | ..... | ..... |
| ESTILL | Jahn A. Patterson, MD, Irvine | Present | Present |
| JACKSON ..... | ..... | ..... | ..... |
| LEE | James B. Nable, MD, Beattyville | ..... | ..... |
| MADISON | Jerame Krumpelman, Jr, MD, Richmand | Present | Present |
| | Gladys Irene Minar, MD, Berea | ..... | ..... |
| | Richard A. Stane, MD, Richmand | Present | Present |
| MENIFEE ..... | ..... | ..... | ..... |
| MONTGOMERY | Lan E. Roberts, Jr, MD, Maunt Sterling | Present | ..... |
| OWSLEY ..... | ..... | ..... | ..... |
| POWELL | Charles G. Nass, MD, Stanton | ..... | ..... |
| WOLFE | Paul Maddax, MD, Compton | ..... | ..... |

TWELFTH DISTRICT

| | | | |
|-------------|------------------------------|---------|-------|
| BOYLE | Brian E. Ellis, MD, Danville | Present | |
|-------------|------------------------------|---------|-------|

| | | | |
|------------------|------------------------------------------|---------|---------|
| | David C. Liebschutz, MD, Danville | Present | Present |
| | Arthur K. Rivard, MD, Danville | Present | Present |
| CASEY ..... | ..... | ..... | ..... |
| CLINTON | Michael Lee Cummings, MD, Albany | ..... | ..... |
| GARRARD | Paul J. Sides, MD, Lancaster | Present | Present |
| LINCOLN ..... | ..... | ..... | ..... |
| MCCREARY ..... | ..... | ..... | ..... |
| MERCER | George W. Nae, MD, Harrodsburg | ..... | ..... |
| PULASKI | Steven M. DeMunbrun, MD, Somerset | Present | Present |
| | Dana L. Gibson, MD, Somerset | Present | Present |
| | Billy Joe Parsan, MD, Somerset | Present | Present |
| ROCKCASTLE | William D. Dooley, MD, Maunt Vernan | ..... | ..... |
| RUSSELL | H. Michael Oghia, MD, Russell Springs | Present | ..... |
| WAYNE | Edward Joseph, MD, Manticella | ..... | ..... |

THIRTEENTH DISTRICT

| | | | |
|----------------|-------------------------------------|---------|---------|
| BOYD | Paul W. Craig, II, MD, Ashland | Present | Present |
| | Maurice J. Oakley, MD, Ashland | Present | Present |
| | Rager Patter, MD, Ashland | ..... | Present |
| | Susan Prasher, MD, Ashland | Present | Present |
| | Charles Watson, MD, Ashland | Present | Present |
| CARTER ..... | ..... | ..... | ..... |
| ELLIOTT ..... | ..... | ..... | ..... |
| GREENUP | Jahn O. Janes, MD, Flatwoods | ..... | ..... |
| | Laurente B. Tigas, MD, Ashland | ..... | ..... |
| LAWRENCE ..... | ..... | ..... | ..... |
| LEWIS ..... | ..... | ..... | ..... |
| MORGAN | George R. Bellamy, MD, West Liberty | ..... | ..... |
| ROWAN | Alan T. Mong, MD, Morehead | ..... | Present |

FOURTEENTH DISTRICT

| | | | |
|-----------------|---------------------------------------|---------|---------|
| BREATHITT ..... | ..... | ..... | ..... |
| FLOYD | Nicholas R. Jurich, MD, Prestansburg | Present | Present |
| | Gangadhar L. Maddiwar, MD, Martin | ..... | ..... |
| JOHNSON | Franklen K. Belhasen, MD, Paintsville | ..... | ..... |
| KNOTT | W. Grady Stumbo, MD, Hindman | ..... | ..... |
| LETCHER ..... | ..... | ..... | ..... |
| MAGOFFIN ..... | ..... | ..... | ..... |
| MARTIN ..... | ..... | ..... | ..... |
| PERRY | Gilray Daley, MD, Hazard | ..... | Present |
| | Becky John, MD, Hazard | Present | Present |
| PIKE | Baretta R. Casey, MD, Pikeville | Present | Present |
| | Gregary Hazelett, MD, Pikeville | Present | Present |
| | Lela C. Maynard, MD, Pikeville | Present | Present |
| | Charles G. Nichols, MD, Pikeville | ..... | Present |

FIFTEENTH DISTRICT

| | | | |
|---------------|------------------------------------|---------|---------|
| BELL | Meredith J. Evans, MD, Middlesbara | Present | Present |
| CLAY | Ira F. Wheeler, MD, Manchester | Present | ..... |
| HARLAN | Sharan M. Caltan, MD, Evarts | ..... | ..... |
| | F. Andrew Marfesis, MD, Harlan | ..... | Present |
| KNOX | Harold L. Bushey, MD, Barbourville | Present | Present |
| LAUREL | William D. Pratt, MD, London | Present | Present |
| | David W. Dauglass, MD, London | Present | ..... |
| LESIE ..... | ..... | ..... | ..... |
| WHITLEY | P. Bruce Barton, MD, Carbin | Present | Present |
| | Nasir Gardezi, MD, Carbin | ..... | ..... |

KMA Student Section

| | | |
|---------------------------------|-------|---------|
| UL-Amy Waltrip, Louisville | ..... | Present |
| UK-Michael T. Newman, Lexington | ..... | Present |

KMA Resident Physicians Section

| | | |
|------------------------------------|-------|-------|
| Brian O'Danoghue, MD, Madisonville | | |
|------------------------------------|-------|-------|

KMA Organized Medical Staff Section

| | | |
|------------------------------|---------|---------|
| William D. Pratt, MD, London | Present | Present |
|------------------------------|---------|---------|

The information in the roll call was taken from the attendance record cards signed by the delegates prior to the meetings of the House, September 26 and September 28.

146th KENTUCKY MEDICAL ASSOCIATION HOUSE OF DELEGATES



KMA's 146th Annual Meeting

Robert G. Cox

KMA's retiring Executive Vice President
addressed the closing session of the
1996 House of Delegates



Index to Proceedings

| | |
|----------------------------------------------------------------------------------|-----|
| Minutes, House of Delegates First Meeting | 553 |
| Minutes, House of Delegates Second Meeting | 554 |
| Ad Hoc Committee to Develop a Comprehensive School Health Education Plan | 593 |
| Ad Hoc Committee to Study Guidelines for Prescribing Controlled Substances | 577 |
| Alliance, Report of the President | 557 |
| Board of Trustees, Chair | 558 |
| Board Meetings, Summary of | 559 |
| Cancer | 570 |
| Care for the Elderly | 576 |
| Changing Trends in Medicine, Committee to Investigate | 585 |
| Child and School Health | 592 |
| Community and Rural Health | 594 |
| Continuing Medical Education | 568 |
| Council for Continuing Medical Education | 568 |
| Delegates to AMA | 561 |
| Editor | 561 |
| Election of 1997 Nominating Committee | 600 |
| Election of Officers | 599 |
| Ephraim McDowell Cambus-Kenneth Foundation, Inc. | 564 |
| Executive Vice President | 562 |
| Interspecialty Council | 593 |
| Joint Oversight Group on Health Care Reform | 593 |
| Judicial Council | 592 |
| KEMPAC Board of Directors, Chair | 583 |
| KMA Physicians Services, Inc. | 564 |
| Kentucky Medical Insurance Company | 564 |
| Maternal and Neonatal Health | 590 |
| Maternal Mortality Study | 578 |
| Medical Insurance and Prepayment Plans | 584 |
| Medical Student Section | 588 |
| National Legislative Activities | 575 |
| Organized Medical Staff Section | 572 |
| Physical Education and Medical Aspects of Sports | 591 |
| Physician Advisory Committee to Health Kentucky | 565 |
| Physician Organization Study | 586 |
| Physician Services (Medicaid), Technical Advisory | 591 |
| Physician Workforce Committee | 570 |
| President | 555 |
| President-Elect | 557 |
| PRO Advisory | 584 |
| Professional Liability Insurance | 575 |
| Public Education | 576 |
| Resident Physicians Section | 588 |
| Rural Kentucky Medical Scholarship Fund | 572 |
| Scientific Exhibits | 570 |
| Scientific Program | 569 |
| Secretary-Treasurer | 560 |
| Speakers, House of Delegates | 558 |
| State Legislative Activities | 578 |
| Statewide Health Information Network Feasibility Study | 595 |
| Young Physicians Steering | 587 |

Index to Resolutions

| Resolution | Subject | |
|------------|--------------------------------------------------------------------------------------|-----|
| 96-101 | Laboratory Accreditation | 573 |
| 96-102 | New Kentucky Medical School | 573 |
| 96-103 | Benefits of Membership in Organized Medicine | 566 |
| 96-104 | Tribute to Physician Elected Officials | 581 |
| 96-105 | "GAG" and "Hold Harmless" Clauses in Managed Care Contracts | 588 |
| 96-106 | The UNISYS Debacle | 588 |
| 96-107 | Managed Care Organization | 589 |
| 96-108 | Medicaid Program | 581 |
| 96-110 | Physician/ARNP Collaborative Agreements | 582 |
| 96-111 | Licensure for Telemedicine | 574 |
| 96-112 | AMA Federation Study | 566 |
| 96-113 | HIV Testing | 597 |
| 96-114 | Patient Protection | 582 |
| 96-115 | Physician Provider Tax | 582 |
| 96-116 | Partners for Family Farms | 597 |
| 96-117 | AMA-CPT Coding | 598 |
| 96-118 | Repeal of Kentucky Certificate of Need Law | 566 |
| 96-119 | Mandated Information for Women Diagnosed with Breast Cancer | 574 |
| 96-120 | Pharmaceutical Manufacturers' Link to Managed Care | 583 |
| 96-121 | HCFA-1500 Form | 598 |
| 96-122 | Kentucky Lawsuit Against FDA Regulations | 599 |
| 96-123 | Guidelines for Ordering Home Health, Rehabilitation, and Ancillary Services | 589 |
| 96-124 | Physician Representation by Organized Medicine | 566 |
| 96-125 | PAP Smear as a "Clinical" Laboratory Test | 574 |
| 96-126 | Primary Care Physicians' Treatment of Depression | 599 |
| 96-127 | Availability of Laboratory Services | 589 |
| 96-128 | School Health Examinations | 567 |

Reference Committees

Special appreciation to the Chairs and members of the Reference Committees for working so diligently to study committee reports, resolutions, and make recommendations to the full House of Delegates.



(L to R) Reference Committee A: Dovid J. Zoeller, MD, Elizabethtown; Bruce A. Scott, MD, Louisville; John D. Stewart, MD, Lexington; Mohon K. Rao, MD, Madisonville, Chair; K. Thomas Reichard, MD, Louisville; Joseph J. Dobner, MD, Frankfort.



Reference Committee B: Brenda I. Townes, MD, Louisville; Gordon W. Air, MD, Crestview Hills; Kothleen J. Bos, MD, Lexington; William D. Pratt, MD, London, Chair; Cecil D. Martin, MD, Corrollton; Michael Todd Newman, MSS, Lexington.



Reference Committee C: Daniel E. Kenady, MD, Lexington, Chair; Lelo C. Maynard, MD, Pikeville; Uday V. Dave, MD, Modisonville; Charles G. Nicholas, MD, Pikeville; Edward L. W. Scofield, MD, Louisville; Brian E. Ellis, MD, Donville.



Reference Committee D: Dovid J. Bensema, MD, Lexington, Chair; Paul W. Craig, MD, Ashland; Billy Joe Parson, MD, Somerset; Thomas E. Bunnell, MD, Erlonger; Kyle H. Kiser, MD, Covington; Robert C. Hughes, MD, Murray.



Reference Committee E: John R. White, MD, Lexington; John A. Potterson, MD, Irvine; Robert L. Baker, Jr, MD, Crescent Springs; Robert J. Emslie, MD, Bowling Green, Chair; Nicholas R. Jurich, MD, Prestonsburg; Michael T. Macforlone, MD, Louisville.

The James W. Kincaid, MD Memorial Meeting of the Kentucky Medical Association

**Digest of Proceedings of the Regular Session of the*

House of Delegates

C. Kenneth Peters, MD, Jeffersontown

Speaker of the House

John W. McClellan, MD, Henderson

Vice Speaker of the House

Presiding

First Meeting September 26, 1996

C Kenneth Peters, MD, Speaker of the KMA House of Delegates, called the first Meeting of the 146th Session of the House of Delegates to order at 9:05 AM on Thursday, September 26, 1996, at the Hyatt Regency Hotel, Louisville, Kentucky. He introduced the Vice Speaker, John W. McClellan, MD, and KMA's Legal Counsel, Charles J. Cronan, IV, Louisville.

The invocation was given by Harold L. Bushey, MD, Barbourville. A motion was made, seconded, and carried to approve the Minutes of the 1995 Session of the House of Delegates as published in the December 1995 *Journal of the Kentucky Medical Association*.

William P. VonderHaar, MD, Louisville, Secretary-Treasurer, announced that the Scientific Session would begin at 8:30 AM on Friday, September 27, and the President's Luncheon would be held on Saturday, September 28, at which time the new President would be installed. Dr VonderHaar reminded the Delegates that reference committees would convene at 1:00 PM on Thursday. He then asked the House members to stand for a moment of silence in memory of KMA members who had died since the 1995 Annual Meeting.

Speaker Peters announced that each delegate's packet contained a booklet prepared by the Rules Committee outlining the rules the House should follow in its deliberations.

Danny M. Clark, MD, President, presented the Educational Achievement Award to Ward O. Griffen, MD, Lexington (which Daniel Kenady, MD, accepted on his behalf); and the Chair of the Awards Committee, Ardis D. Hoven, MD, presented John P. Stewart, MD, Frankfort, with the 1996 Distinguished Service Award. Maria Vieillard, Immediate Past President of the KMA Alliance, presented AMA-ERF checks comprised of funds the Alliance had raised to benefit Kentucky's

medical schools. Emery A. Wilson, MD, Dean, accepted a check in the amount of \$14,376.00 on behalf of the University of Kentucky College of Medicine; and Alfred L. Thompson, MD, Vice President for Clinical Affairs, accepted a check for \$20,115.56 on behalf of the University of Louisville School of Medicine.

Dr Peters noted that a "tribute" resolution honoring Steven L. Salman (KMIC) had been introduced. The resolution was read, and a motion was made, seconded, and carried to adopt the resolution as written.

Tribute to Steven L. Salman Board of Trustees

WHEREAS, Steven L. Salman has served with distinction as President and Chief Executive Officer of the Kentucky Medical Insurance Company (KMIC), and

WHEREAS, Steven L. Salman provided important and timely leadership by guiding KMIC through extremely difficult financial and other industry-wide and corporate changes, and

WHEREAS, KMIC has weathered enormous global marketplace trends and as a result has been granted the highest ratings in its eighteen year history by prestigious insurance rating companies, and

WHEREAS, KMIC's aggressive management practices, under the leadership of Steven L. Salman, have provided stability to a volatile professional liability market, and

WHEREAS, Steven L. Salman has announced his resignation as President and CEO of KMIC to accept the Presidency of another physician-owned company, therefore be it

RESOLVED, that the 1996 KMA House of Delegates recognizes the important contributions of Steven L. Salman to the medical environment in Kentucky for the practice of medicine and the delivery of patient care and, be it further

RESOLVED, that the 1996 KMA House of Delegates wishes for Steven L. Salman and his family the very best for the future, and be it further

RESOLVED, that a copy of this resolution be presented to Steven L. Salman and that he be granted the privilege of the House floor for appropriate remarks.

Dr Peters introduced the officers who presented their reports. In the Report of the President, Dr Clark indicated that Robert G. Cox had announced his retirement, and that the Board of Trustees had named William T. Applegate as the Executive Vice President-Designate. Each of the officers reports was assigned to a reference committee as noted:

***Editorial Note: A tape recording was made of the two meetings of the House of Delegates, and any member who wishes to examine the transcript of these Proceedings may visit the Headquarters Office and listen to the recordings.**



| Report Number | | Reference Committee |
|---------------|--------------------------------------------------------------------------|---------------------|
| 1 | Report of the President | A |
| 2 | Report of the President, Alliance | A |
| 3 | Report of the President-Elect | A |
| 4 | Report of the Speakers, House of Delegates | A |
| 5 | Report of the Chair, Board of Trustees | A |
| 6 | Report of the Secretary-Treasurer | A |
| 7 | Report of the Editor | A |
| 8 | Report of the Delegates to AMA | A |
| 9 | Report of the Executive Vice President | A |
| 10 | Report of KMA Physicians Services, Inc | A |
| 11 | Report of the Kentucky Medical Insurance Company | A |
| 12 | Report of the EMCK Foundation | A |
| 13 | Physician Advisory Committee to Health Kentucky | A |
| 14 | Scientific Program Committee | B |
| 15 | Scientific Exhibits Committee | B |
| 16 | Continuing Medical Education Committee | B |
| 17 | Council for Continuing Medical Education | B |
| 18 | Cancer Committee | B |
| 19 | Physician Workforce Committee | B |
| 20 | Organized Medical Staff Section | B |
| 21 | Rural Kentucky Medical Scholarship Fund | B |
| 22 | Maternal Mortality Study Committee | C |
| 23 | Committee on National Legislative Activities | C |
| 24 | Committee on State Legislative Activities | C |
| 25 | Committee on Professional Liability Insurance | C |
| 26 | Committee on Care of the Elderly | C |
| 27 | Public Education Committee | C |
| | Ad Hoc Committee on Controlled Substances | C |
| 28 | Committee on Medical Insurance and Prepayment Plans | C |
| 29 | PRO Advisory Committee | D |
| 30 | Committee to Investigate Changing Trends in Medicine | D |
| 31 | Physician Organization Study Committee | D |
| 32 | Young Physicians Steering Committee | D |
| 33 | Resident Physicians Section | D |
| 34 | Medical Student Section | D |
| 35 | Committee on Maternal and Neonatal Health | E |
| 36 | Technical Advisory Committee on Physician Services (Medicaid) | E |
| 37 | Committee on Community and Rural Health | E |
| 38 | Committee on Physical Education and Medical Aspects of Sports | E |
| 39 | Committee on Child and School Health | E |
| 40 | Judicial Council | E |
| 41 | Joint Oversight Group on Health Care Reform | E |
| 42 | Statewide Health Information Network Feasibility Study Committee | E |
| 43 | Interspecialty Council | E |
| | Ad Hoc Committee to Develop a Comprehensive School Health Education Plan | E |

New Business

New Business of the House was assigned to the Reference Committee indicated:

| Resolution | Submitted by | Subject | Reference Committee |
|------------|--------------------------------------|-------------------------------------------------------------|---------------------|
| 101 | Nancy Swikert, MD President, KAFP | Laboratory Accreditation | B |
| 102 | Board of Trustees | New Kentucky Medical School | B |
| 103 | Board of Trustees | Membership in the Federation | A |
| 104 | Board of Trustees | Tribute to Physician Elected Officials | C |
| 105 | Board of Trustees | "Gag" and "Hold Harmless" Clauses in Managed Care Contracts | D |
| 106 | Board of Trustees | The UNISYS Debacle | D |
| 107 | Board of Trustees | Managed Care Organization | D |
| 108 | FCMS | Medicaid Program | C |
| 110 | Board of Trustees | Physician/ARNP Collaborative Agreements | C |
| 111 | JCMS | Licensure for Telemedicine | B |
| 112 | JCMS | AMA Federation Study | A |
| 113 | JCMS | HIV Testing | E |

| | | | |
|-----|--------------------------------------|----------------------------------------------------------------------------|---|
| 114 | JCMS | Patient Protection | C |
| 115 | Northern Kentucky Medical Society | Physician Provider Tax | C |
| 116 | Estill County Medical Society | Partners for Family Farms | E |
| 117 | Northern Kentucky Medical Society | AMA-CPT Coding | E |
| 118 | Franklin County Medical Society | Repeal of Kentucky Certificate of Need Law | A |
| 119 | JCMS | Mandated Information for Women Diagnosed with Breast Cancer | B |
| 120 | FCMS | Pharmaceutical Manufacturers' Link to Managed Care | C |
| 121 | FMCS | HCFA-1500 Form | E |
| 122 | FCMS | Kentucky Lawsuit Against FDA Regulations | E |
| 123 | FCMS | Guidelines for Ordering Home Health, Rehabilitation and Ancillary Services | D |
| 124 | FCMS | Physician Representation by Organized Medicine | A |
| 125 | FCMS | Pap Smear as a "Clinical" Laboratory Test | B |
| 126 | Nancy Swikert, MD President, KAFP | Primary Care Physicians' Treatment of Depression | E |
| 127 | Board of Trustees | Availability of Laboratory Services | D |
| 128 | Board of Trustees | School Health Examinations | A |

Vice Speaker McClellan announced the meeting locations for the Nominating Committee and for Trustee Districts electing Trustees and Alternate Trustees. He reminded the Delegates that the Nominating Committee would report at the close of the first Scientific Session on Friday morning.

The names of the Nominating Committee members were announced: Susan G. Bornstein, MD, Louisville, Chair; John T. Burch, MD, Bowling Green; Charles G. Nichols, MD, Pikeville; Thomas R. Slabaugh, MD, Lexington; and Charles T. Watson, MD, Ashland.

The Vice Speaker adjourned the First Meeting at 10:15 AM.

Second Meeting September 28, 1996

C. Kenneth Peters, MD, Speaker, House of Delegates, called the Second Meeting of the 1996 Session of the KMA House of Delegates to order at 7:00 PM on Saturday, September 28, 1996.

Barbara Phillips, MD, Lexington, gave the Invocation, and Jayne Hollender, MD, Louisville, Chair of the Credentials Committee, reported that a quorum was present.

Secretary-Treasurer Vonderhaar recognized guests from neighboring state medical associations who had attended the Annual Meeting. Included were Jerome Melchior, MD, President, Indiana State Medical Association; Kenneth D. Tuck, MD, President-Elect, Medical Society of Virginia; John F. Kroner, Jr, MD, President, Ohio State Medical Association; and Daniel F. O'Sullivan, MD, President, Missouri State Medical Association. Also recognized were Nancy Kintzel, an AMA Field Services representative, and Thomas C. Payne, MD, member of the AMPAC Board of Directors.

KMA President, Danny M. Clark, MD, introduced Lieutenant Governor Steve Henry, MD, who addressed the House of Delegates. Dr Henry expressed his thanks to KMA members who worked with the Administration in a cooperative spirit on matters such as the provider tax and Medicaid reimbursement.

In regard to the recent court settlement, Dr Henry indicated that physicians would first receive a letter providing the state's figures on the amount they had billed. They will be asked to indicate agreement or disagreement with these figures. He noted there had been problems obtaining these figures from UNISYS, but if all goes well, checks should be issued no later than November 15.

Dr Henry then challenged physicians to get political, and become involved in the future of the managed care issue. He expressed the Administration's desire for input from KMA and the need for reasonable, ethical reforms. He noted that

there are many challenges in medicine, but the Patton administration is willing and eager to work with Kentucky's physicians to make medical care in Kentucky great.

Harry W. Carlross, MD, Chair, Board of Trustees, was called upon to make a final report. Two new "tribute" resolutions were introduced by the Board of Trustees. The first was in honor of William P. VonderHaar, MD, for his service to KEMPAC from 1994 to 1996, and the second was in honor of Robert G. Cox, KMA Executive Vice President upon the announcement of his retirement after 35 years of service to the Association (1962-1997). The Resolutions were read, and a motion was made, seconded, and carried to adopt each as written.

Tribute to William P. VonderHaar, MD Board of Trustees

WHEREAS, William P. VonderHaar, MD, has served with distinction as Chair of the KEMPAC Board of Directors for two consecutive terms; and;

WHEREAS, members of KEMPAC and the KEMPAC Board of Directors played a significant role in KMA's legislative victories in 1996; and;

WHEREAS, William P. VonderHaar, MD, has led KEMPAC to two consecutive record membership years; and;

WHEREAS, the AMA and AMPAC have honored KEMPAC with three national awards during William P. VonderHaar's tenure as Chair of KEMPAC, therefore be it

RESOLVED, that the 1996 KMA House of Delegates recognizes William P. VonderHaar, MD, for his devotion to duty and his extraordinary efforts as Chair of KEMPAC from 1994 to 1996, and be it further

RESOLVED, that the House of Delegates extends its best wishes and appreciation to William P. VonderHaar, MD, for a job well done and be it further

RESOLVED, that a copy of this Resolution be framed and presented to Doctor VonderHaar.

Tribute to Robert G. Cox, KMA Executive Vice President 1968-1997 Board of Trustees

WHEREAS, Robert G. Cox, Executive Vice President of the Kentucky Medical Association has announced his retirement effective January 2, 1997; and

WHEREAS, Robert G. Cox has served the physicians of Kentucky and the Kentucky Medical Association faithfully 35 years, 28 as Executive Vice President and Chief Operating Officer; and

WHEREAS, KMA, upon Mr Cox's elevation to CEO in 1968, had a total reserve of \$45,066 and on June 30, 1996, had climbed to \$3,955,233; total assets in 1968 were \$444,620 and today, assets are \$7,342,686; total income has risen from \$197,000 to \$3,050,078; and KMA membership has almost tripled; and

WHEREAS, Robert G. Cox's financial and business skills have contributed dramatically to the stability of this Association and the conservative dues structure which is recognized nationally as one of the outstanding state medical associations in the country; and

WHEREAS, his greatest legacy to the Association, physician community, and the public is the maintenance and strengthening of the enormous prestige and respect accorded the Kentucky Medical Association throughout the Commonwealth and the US; now, therefore, be it

RESOLVED, that the 1996 Kentucky Medical Association congratulates and extends its best wishes for a long and happy retirement for Bob and his wonderful wife, Kay Cox; and be it further

RESOLVED, that this House of Delegates is extremely appreciative of Mr Cox's long and distinguished career as a member of KMA staff and a leader of the health industry in Kentucky; and be it further

RESOLVED, that the final session of the KMA House of Delegates honors Robert G. Cox and accords him the privilege of the 1996 House of Delegates floor; and be it further

RESOLVED, that a framed copy of this Resolution be presented to Robert G. Cox and that this Resolution and presentation be made a part of the permanent records of this Association.

The Speaker then called for the Reference Committee Chairs to present their Reports.

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE A

Mohan K. Rao, MD, Madisonville, Chair

1. Report of the President
 2. Report of the President, Alliance
 3. Report of the President-Elect
 4. Report of the Speakers, House of Delegates
 5. Report of the Chair, Board of Trustees
 6. Report of the Secretary-Treasurer
 7. Report of the Editor
 8. Report of the Delegates to AMA
 9. Report of the Executive Vice President
 10. Report of KMA Physicians Services, Inc
 11. Report of the Kentucky Medical Insurance Company
 12. Report of the EMCK Foundation
 13. Report of the Physician Advisory Committee to Health Kentucky
- Resolution 103 — Membership in the Federation
(Board of Trustees)
- Resolution 112 — AMA Federation Study
(Jefferson County Medical Society)
- Resolution 118 — Repeal of Kentucky Certificate of Need Law
(Franklin County Medical Society)
- Resolution 124 — Physician Representation by Organized Medicine
(Fayette County Medical Society)
- Resolution 128 — School Health Examiners
(Board of Trustees)

ITEMS FOR CONSENT

Reference Committee A reviewed the following items and recommends they be filed, by consent of the House, without discussion:

1. Report of the President — filed
2. Report of the President, Alliance — filed
3. Report of the President-Elect — filed
4. Report of the Speakers, House of Delegates — filed
5. Report of the Chair, Board of Trustees — filed
6. Report of the Secretary-Treasurer — filed
7. Report of the Editor — filed
8. Report of the Delegates to AMA — filed
9. Report of the Executive Vice President — filed
10. Report of KMA Physicians Services, Inc — filed
11. Report of the Kentucky Medical Insurance Company — filed
12. Report of the EMCK Foundation — filed

The members of Reference Committee A would like especially to recognize the report of KMA President Danny Clark, MD and to commend him for outstanding service to the organization and the state of Kentucky over the last year. Additionally, members of Reference Committee A would like to offer special commendation and appreciation to Executive Vice President Bob Cox for his 35 years of dedicated service to the Kentucky Medical Association.

Mr Speaker, Reference Committee A thanks these officers and committees for their efforts and recommends adoption of the Consent Calendar as a whole.

Report of the President

It is my privilege to present my final report to you as President of the Association. This has been a particularly busy and involved year for the officers, Board of Trustees, staff, and many other members of the Association, and I hope all of these efforts have been as productive as they have been intense.

The most focused part of the year revolved around state legislative activities. Beginning in December, the officers began a series of meetings that were the start of a legislative roller coaster ride that has not yet fully stopped. From the outset, the leadership was constantly required to weigh the possible against the ideal in terms of legislative goals. Our task throughout the legislative session was to balance the mood of the Administration and the Legislature with the needs of the membership.

Our work began with private meetings with the Governor, Lt Governor, and their staff, primarily about the provider tax as well as related issues dealing with the old HB 250. At every step the Governor, Lt Governor, and their staff representatives dealt in good faith with the KMA leadership,



particularly in light of the political realities that both sides were required to confront. While our dealings with the Legislature as a whole were not as gratifying, the result of all this work was, as everyone knows, an incremental dissolution of the provider tax with increased funding for the Medicaid program, both from settlement of the KMA suit against the previous Administration's imposition of Medicaid changes, and additional money provided for physician reimbursement by the Patton Administration. We also were able to do away with most of the onerous parts of HB 250.

During this process there were honest differences of opinion among the membership which were all equally valid. It was the position of the leadership that complete revocation of the provider tax was not legislatively possible. Even had the tax been rescinded, the resulting decrease in funding of the Medicaid program would have been severe. In the midst of the legislative session, a Special Session of the KMA House of Delegates was called, at the request of members, to evaluate KMA's position. The direction charted by the KMA leadership was affirmed.

This has been a divisive issue for our membership and no view should be discounted or dismissed. I am particularly sensitive to the significance of this matter, and continue to be committed to actions taken by the officers and Board of Trustees and remain prepared to defend them. Regardless of differing viewpoints, the result of these procedures has been an infusion of \$104 million into the physician reimbursement component of Medicaid, and an ultimate repeal of the provider tax.

In this context, I would be remiss if I didn't note the commendable efforts of many individuals and groups of physicians around the state who took a direct part in not only the legislative, but the political process as well. As many know, local contact with legislators is the key element of medicine's influence. Any legislative success we recognize was a direct result of local physician contacts. The simplicity of this effectiveness is fateful.

It is both astounding and alarming that such a relatively small number of physicians and their spouses participate in the legislative process simply through campaign contributions, and even more basically, through voting. Given the fact that government-based compensation by physicians through Medicare, Medicaid, Workers' Compensation, and other sources comprises 50% of all payments, it is difficult to believe that more physicians are not involved. When such a small segment of society can have such a significant impact on our professional, social, economic, and personal lives, it is senseless that we do not better exercise our constitutionally based right to require legislators to face the electorate. Physicians, their families, and their staffs must become more involved in the political process. Your future is being determined in Frankfort and Washington, and to sit idly by and let our legislators control it without strong local input from all of us is sheer folly. If you allow this, blame yourselves, for no organization — including the Kentucky Medical Association — can approach the effectiveness that constituents themselves have with their legislators.

A second major issue confronted this year has been claims management in the Medicaid program by UNISYS, the fiscal contractor. I won't recount the various difficulties all of us have experienced. The leadership has been engaged in countless meetings with both the Administration and UNISYS representatives, and I am sure there are a variety of logical reasons for all of the difficulties. However, the end result of the UNISYS situation is intolerable. Furthermore, it is likely that the performance of UNISYS will also affect payment of Medicaid funds in settlement of the lawsuit by Governor Patton. Most recently, we have learned that UNISYS will likely be able to process current claims soon, although a backlog of paper claims and claims submitted with attachments will probably remain until the end of the year. The KMA leadership, along with members of the General Assembly and Administration representatives, have brought all reasonable pressure to bear on UNISYS, which includes imposition by the state of financial penalties. Although not of immediate consolation, I am convinced that the current Administration is making appropriate good faith efforts to correct the situation.

Another major focus this year has been dealing with managed care issues. The buzz word "managed care" defines a method of medical care delivery different from what most of us trained under. Managed care is corporate America's answer to perceived faults in the health care system. To my mind, the quality of medicine was never at fault or in question. Linking provider reimbursement to limiting care is not the answer, and providing more efficient care should not mean limiting the care that is

necessary for the well-being of our patients. These decisions should be made by the physicians who are caring for the patients and not by faceless entities who never see our patients. Providing care more efficiently, reducing redundancy, and trimming unnecessary costs are appropriate. Regardless of the method of delivery, the art of medicine must prevail, and we should all renew our commitment to this art. In the midst of this change, however, we must make sure that a flawed system is not replaced with one that has greater faults.

As you know, the Board of Trustees has begun the initial steps in forming a statewide preferred provider organization with the potential of serving the state employees group, or the Kentucky Kare program. More information will be provided to you during the Annual Meeting, and you will be asked to provide direction to the Board on this issue. As proposed, KMA would work in cooperation with a managed care administrative organization, Preferred Health Choice, to provide preliminary information so that an educated decision can be made. We have thus far conducted a survey of the interest of members, explored the formation of a subsidiary organization, evaluated a potential agreement between PHC and HMO, and considered other aspects of KMA's involvement.

I think that this course is appropriate. If we as physicians blame managed care for the ills of health care delivery, then we must either become involved to correct those ills, or suffer from them and rely on the direction of others. It is vital that we use our influence to be responsible for our own future.

My personal experiences as President this year have been fascinating and challenging. I have had the privilege of traveling around the state, as well as outside it. The differences among individual doctors and groups of physicians are varied and rich, and are part of the strength of our profession. This is, likewise, a potential weakness. I believe very strongly in the benefit of this diversification and the lively disagreement it sometimes brings. I believe equally as strongly in consensus opinion. I can honestly say that I have disagreed with the Board of Trustees and the House of Delegates from time to time, but once an issue is voted, I feel compelled to support the consensus position. To do otherwise would be a faithless act on my part. There are far too many issues and efforts attacking our professional world outside the fraternity of medicine to be less than united. Unless we are cohesive following our collective agreement, our art and science are jeopardized.

The retirement this year of Robert G. Cox, our Executive Vice President of 35 years, is also a significant issue, both for the Association, and for me personally. When I first became active in KMA as a Delegate 25 years ago, I knew him from a distance, and have since come to know him very closely. I consider him a personal friend, and feel honored to have known and worked with him. I have developed a deep respect for his ability to deal with all the problems medicine has to face, manage the business of the Association, and operate effectively with the disparate personalities that our Association produces.

In my travels around the state and the country, I have learned that many share the esteem I have for him and the capability of our Association under his guidance. For many years, I have witnessed his life-long dedication to this Association and the medical profession. He will be sorely missed as the chief executive, and I will miss him personally. It is with the sincerest respect that I bid him farewell from his duties with KMA.

In follow up to Bob Cox's retirement, I am pleased to acknowledge that the Board of Trustees has named William T. Applegate as Executive Vice President Designate. Bill has worked for KMA for over 28 years and is a true product of the "medical association" industry. For the past several years he has served as Deputy Executive Vice President, and I and the Board of Trustees are confident in his abilities and leadership and gratified with his acceptance of this position. Having worked closely for a number of years with various members of our staff, I can only echo what all of the previous presidents have said. They are dedicated, hard-working, and certainly get things done. I feel that we are very fortunate to have such talent and dedication in our staff, and they certainly are to be commended for their work.

I can't adequately describe the gratitude and fulfillment this year has provided to me. As President, the year has been busy, hectic, challenging, and mostly, rewarding. This year has been the pinnacle of my involvement with KMA. For this I humbly thank the House of Delegates and the membership for your support and trust. The successes that we have had this year

are due to the efforts of many people. Your officers and trustees have worked diligently, and the Association owes them a debt of gratitude for the time they have taken away from their practices and their families. Finally, I would like to thank my wife for her help and for being the most important part of my life. Her encouragement and understanding form the basis for my commitment to our profession and our patients. Again, thank you for giving me the opportunity to serve you.

**Danny M. Clark, MD
President**

Report of the President, Alliance

The President's theme for the year was "Shared Vision and Voice, KMAA is the Right Choice and Together Everyone Achieves More." The counties diligently worked together with the state on our goals for the year. In addition, we reached many members through the *Bluegrass News* quarterly issues to keep them updated on past and future events. The President sent out monthly or bi-monthly *AllianceLine* issues to keep all Board members on the KMAA and KMA apprised of what is being or had been done, and all upcoming projects or meetings. The membership had a very busy year completing all their projects and fund-raisers.

We shared the benefits of the Alliance and membership with new, old, and potential members. We continued to use member-at-large coordinators in our unorganized areas. The number of coordinators will be increased next year. We worked hard to keep communication lines open. We retained all our organized counties; there is a potential for two to three new ones to organize next year. We met with their potential members more than once. A new membership brochure was developed this year along with a new Alliance benefits postcard. We also used literature from the AMAA. We are down a few members due to legislative apathy and HMOs/reorganization of some practices. This temporary setback should be easily overcome.

AMA-ERF was supported with holiday sharing cards, basket auctions, a trash and treasure sale, a Christmas boutique, attic sales, gourmet dinners, convention boutiques, and honoree and memorial cards. Our total at the end of April was \$46,478.19. The largest county contribution was \$20,640.00 from Boyd County with 67 members. The second highest county total was \$7,707.00 from McCracken with 119 members.

Our health scholarship fund-raiser is another important area that the Alliance works formidably to support. Most of these scholarships are in nursing, but some are for allied health fields. County Alliance events that were held included a "Day at the Track," trash and treasure sale with a preview party, "Make-it, Bake-it, Sew-it & Grow-it Sale," and a Rock'N Bowl party. These events netted approximately \$55,000.

Health and disease prevention issues were addressed. The brochure, *Combating the Negative Effects of Media on Children and Youth*, was reprinted with the permission of The Center for Media Literacy in California. Five thousand of these brochures were distributed in Medical Alliance month (March) as a state SAVE project. SAVE is National's Stop America's Violence Everywhere program. As a federated project, this is focused on all year with the National Media Day, the second Wednesday of each October. We will also be incorporating Save-a-Shelter into this project. Our other state SAVE project was the distribution of 10,000 *I Can Choose* coloring books in coalition with the Kentucky Medical Association Public Education Committee. A special sponsorship logo was designed, with children in mind, and printed on the back of the books. We had an additional 5,600 requests for these books after an article appeared in *Mediscope*. This was a very successful project that has opened the doors to new publicity that we care about our communities and we do give back educational resources to them. This project could easily be continued with a few modifications. There are other books in the series developed by the AMAA that could also be used. To develop our own would be reinventing the wheel. These materials have a proven track record.

KENTUCKY'S COUNTY ALLIANCES PROMOTED SAVE DAY IN VARIOUS WAYS:

- A psychiatrist spoke on breaking the cycle of violence and a candlelight walk in Central Park followed the presentation.
- Continuing education classes were held to help a spouse abuse center.
- A fund-raiser was held for a women and families center.
- A mayoral proclamation.

- The *I Can Choose* books were read and colored with children in a housing project playroom.
- A heavy duty commercial washer was purchased and presented to a spouse abuse center.
- A candlelight walk was held from the courthouse to the Ohio River where a wreath was placed in memory of a five year-old who was recently killed by the mother's boyfriend.
- A ecumenical prayer service was held at a hospital chapel.
- Three counties sponsored a SAVE poster contest. Judges were a health columnist, Alliance members, an anchorwoman, and a children's museum director. The posters were exhibited at local malls and hospitals, and the contest finished with a three-week exhibit at the Children's Museum in Cincinnati, Ohio.
- The Perry County Medical Alliance distributed all three health promotion books to their kindergartens and received recognition in the AMAA magazine for this project.
- The movie "Strange Days" was shown in a theater last October which dealt with rape as the story line. This county recently had a community member raped in a church. Alliance members called the theater owner until he agreed to only show the movie for one week instead of two.
- Alliance members spoke to teen groups that had conflict resolution classes.
- SMART is an anti-smoking program developed by two Fayette County Alliance members. It has been endorsed by the American Cancer Society and was sold to the American Lung Association. Three other county Alliances also used this program in 1995-96.
- Growing Healthy is a program for all school levels. Perry County saw a need and worked and raised the money to bring this program to the local school system. Initial costs range from \$16,000 to \$25,000. Carolyn Daley initiated this drive and her Alliance members and the community sponsors responded. The Perry County Alliance won a HAP (Health Awareness Promotion) award at the AMAA National Convention in June for this endeavor.
- 1,500 "Parties and Teens" pamphlets were given to eighth graders.
- 2,000 "800" number crisis cards for spouse abuse victims were printed and put in physicians' offices.

The KMAA continues to support the McDowell House in Danville. The Winter Board was held there to give new board members a chance to visit if they had never been. Carol Senn and her staff are always glad for us to come. A basket auction was held at the April Convention to help raise funds for additional personnel. Over \$1,200 was raised.

Legislation was continuously addressed by our members. We attended the pre-legislative seminars; compiled FAX lists, E-mail lists, phone bank and tree lists; held voter registration drives; and distributed over 800 Medicaid and Provider Tax fact pocket cards to Alliance members. We got to know our legislators at all levels and made contributions of time and dollars. We showed and voiced a united front. This was very evident at the "Day at the Capitol." The united front and strong involvement of the Alliance helped in getting the Provider Tax removed.

It was a privilege and honor to serve as the Alliance's President. I wish my successors the best in 1996-1997 in their continued efforts on the Alliance's behalf. I appreciate the support and friendship of the Kentucky Medical Association and the KMAA office staff. Thank you.

**Marla Vieillard
President, 1995-1996**

Report of the President-Elect

This has been a remarkable year for Kentucky medicine. Remarkable in the volume and complexity of issues that faced us, in the intense commitment KMA physicians made to our legislative effort, in the major success we had — and remarkable that there are so many challenges still ahead.

It has been a rare privilege to serve you as President-Elect and to be a part of the significant effort made to represent the membership's best interest and that of our patients. My first inkling of the seriousness with which your leadership takes its responsibility came when President Clark picked me up in a driving blizzard and drove through ten inches of snow to meet with the Governor, Lieutenant Governor, and their staff last January.

The major thrust of our effort this year was in state legislation. While the



provider tax was an issue everyone felt strongly about, our most significant accomplishment may well have been the revision made to the so-called Health Care Reform legislation of 1994. Left unchanged, the legacy of the Jones administration had the potential for becoming an endless source of undesirable rules, regulations, guidelines, and parameters which would have been placed on physicians, hospitals, and our patients. KMA was able to cause repeal of most areas of concern to physicians while helping preserve sections of the law felt to be desirable.

A second, but none-the-less important victory, was the settlement of KMA's suit against CHR over its arbitrary and ill-conceived cuts in the Medicaid program. The restoration of \$52 million in previously cut physician payments and the addition of another \$52 million in physician payments over the next two years (a total of \$104 million) were achieved by KMA. For rural physicians, especially, this was a very meaningful development.

This occurred because KMA met these challenges head on. KMA recognized that the most likely solution was a political one and carefully implemented its plan for a legislative remedy. Even though we were hammered by the press, which sought to portray some physicians as greedy because they served the very population society asked them to care for, KMA's approach prevailed and served its membership well.

Managed care has come to Kentucky and shows no sign of being a passing fad. KMA's response has been to thoughtfully evaluate our current circumstances, develop a vision of the future, and carefully weigh our options. As a result, KMA is considering the formation of a statewide managed care organization to help our membership not only survive, but flourish in this new environment.

Based on the frustration and outrage many of us feel daily in our struggle with insurance carriers and other third parties, many physicians feel the profession could do a much better job through our own organization. As I write this report, many physicians have voiced their support of such an effort. Hopefully, as more information emerges, that support will evolve into commitment and resolve, so whatever approach we take will be successful in the long term. It is my belief that physicians in Kentucky have the will necessary to make such a venture work.

I look forward to serving you this coming year and pledge my energy, objective reflection, and unwavering commitment to the ideals and principles of our profession and to the policies of the Association. I appreciate the honor you have bestowed upon me.

William H. Mitchell, MD
President-Elect

Report of the Speakers, House of Delegates

Welcome to the 146th KMA Annual Meeting, and greetings from your Speakers. We anticipate an interesting and productive meeting, and urge your participation.

This year we are trying a new format for the meeting based on a survey of the members of the House of Delegates. As you know, the bulk of the meeting will begin at the end of the week and go through part of the weekend. This change was made to accommodate your schedules and your stated preference, and we hope that this will increase your participation and the interchange of ideas. As always, our primary goal is to serve the interests of the House.

Some other changes have occurred this year to which we invite your attention. Reference committees are now designated by letter, rather than number. We have also changed the designation of resolutions. Each resolution will be numbered, beginning with a two-digit year designation, followed by a three-digit number. Both these changes were made to make identification of business items easier and to avoid confusion.

We have made every effort to include those individuals interested on reference committees. Our primary efforts were to involve young physicians, women, and minorities, which are the segments that hold the future of our association. In appointing reference committees, we also take into account geographical representation and previous experience. We strongly encourage all Delegates or members who are interested in participating on reference committees to make themselves known to us to develop more direct influence in the governing process.

This year there will be major issues for consideration by the House, just as there have been major issues confronting the profession. These

include various managed care matters, the formation of an Association-sponsored preferred provider organization, issues relating to various aspects of Medicaid, state and national legislative matters, and others. At this meeting we will also be pleased to welcome the new Executive Vice President of the American Medical Association, P. John Seward, MD, who will address the KEMPAC banquet.

These are difficult, complex, and yet exciting times for medicine, and it is vital that you participate in the meeting to direct the ways in which your organization meets these challenges.

Your Speakers eagerly anticipate these challenges and deeply appreciate the trust you have placed in us by allowing us to serve in these positions. Throughout the meeting, your Speakers will be available to any Delegate or member for consultation, to answer questions, or to receive direction.

C. Kenneth Peters, MD
Speaker, House of Delegates

John W. McClellan, MD
Vice Speaker, House of Delegates

Report of the Chair, Board of Trustees

This being my first experience in presenting a Chair of the Board's report to you and describing the activities of your association these past 12 months is more than a challenge in itself. It has been a fast-moving year, and a highly successful year for KMA.

Your officers, Board, and committee members have committed more time and energy than any time in the past to work on behalf of our profession. I want to express my gratitude to them on behalf of every physician in this state.

The Board of Trustees held ten meetings this year, the Executive Committee met an additional eight times, and the Quick Action Committee conducted 14 meetings to address the timely business of this association. As you know, the House of Delegates was also called into Special Session this year.

This busiest year in our history found us in the ready position 24 hours a day throughout the 1996 Kentucky General Assembly, January through mid-April. The efforts of physicians statewide with legislators peaked at an all time high and we were more successful than any time in history. Details are presented elsewhere in our final reports.

Before, during, and after the Legislature, Medicaid demanded much of our attention. Sometimes it is difficult to tell if you win or lose the daily Medicaid skirmishes; but one thing is for sure, our people were there and fought the good fight. Our big victory was the resolution of our lawsuit against the state concerning Medicaid reimbursement reductions in 1994. As a result of KMA's action, physicians in this state participating in the Medicaid program will be refunded \$52 million for cuts taken, and an additional \$26 million will be budgeted for physician payment during 1996-97, and \$26 million again in the 1997-98 fiscal year. This is a total of \$104 million more Medicaid for physicians as a result of KMA's lawsuit. (That alone makes our dues quite inexpensive.)

In recent weeks, KMA has been busy researching and doing the preliminary work in establishing a statewide PPO for our membership. You will be asked to vote on this concept. Since a survey showed that 92% of our membership favored forming a PPO, a good bit of groundwork has been laid and the final formalities can take place in the immediate future.

We have also been busy this year finalizing plans for the new headquarters office. We have entered into a ten-year lease of a new building and during the past three months have directed the construction of the interior to our specifications. Our new address will be The KMA Building, 4965 US Highway 42, Suite 2000, Louisville, Kentucky, 40222; and we anticipate moving on October 18.

We also voted to merge KMIC with a Michigan physician-owned company and finalized a new endorsement contract with KMIC under its new ownership. We think this merger will prove to be a real plus for our company, as we see more mergers happening in the future.

As stated earlier, we are extremely proud of the commitment and the hard work of our officers, Board and committee members, delegates, and local physicians from across the state. The results we received were the fruit of those ongoing efforts. It was a lesson we cannot afford to forget and

local physician involvement must intensify. As a first-year Board Chair, I had a unique opportunity to observe staff on a day-to-day basis; and I can report to you that the experienced, dedicated, and result-oriented staff we have is unmatched anywhere by any association. We are appreciative of each and every one of them.

The many meetings required to conduct the business of our association in today's climate is mind-boggling. The officers conducted 31 separate meetings to set policy on matters requiring our attention. This doesn't take into account the numerous other committee and unannounced meetings which they attend on a routine basis. There is indeed a heavy commitment of time and I think all of us should understand their commitment and recognize them for their sacrifice.

Even though much of our effort was centered on legislative matters, we, of course, continued all of our other association responsibilities to our members and the public through the programs of some 40 hard-working committees. Whether we are sponsoring workshops; an Annual Meeting; providing CME accreditation for institutions; communicating with the public; representing medicine with government, allied groups, and third parties; or attending regional or national meetings to better serve Kentucky physicians, KMA is there every minute to provide services and support.

There is no doubt this was our busiest year ever. However, events occurring on a daily basis in medicine indicate that the future offers no promise of less activity. There are many changes taking place. This year in Frankfort we ridded ourselves of onerous portions of HB 250, the provider tax is on the way to being history, and the Medicaid lawsuit settlement in our favor are all significant achievements. But more problems and more opportunities will face us. With your support, we will be prepared to meet them.

A report on the Legal Trust Fund is included annually in the Chair's Report. Our income this year was \$107,248 with expenses of \$18,916. The Fund's balance as we prepared this report was \$226,970. The Board recommends that the Legal Trust Fund voluntary assessment for next year be \$25 per member.

The following summary of Board meetings is designed to give you a quick review of your Board's activities this year. All committees have their own separate report for your study. Complete minutes of all Board meetings will be provided to Reference Committee Chair A. Reading these reports helps provide you with an insight as to the involvement of KMA on your behalf. We exist to provide services to you and for you. I think we do it well.

Summary of Board Meetings

First Meeting, September 21, 1995

The KMA Board of Trustees held its reorganizational meeting for the 1995-96 Association year on September 21, 1995. Acting as temporary Chair, KMA Secretary-Treasurer William P. VonderHaar, MD, introduced the newly elected members of the Board and the new officers. William H. Mitchell, MD, Richmond, was elected President-Elect; and Don R. Stephens, MD, Cynthiana, was elected Vice President. C. Kenneth Peters, MD, Jefferson-town, as reelected Speaker, House of Delegates; and John W. McClellan, MD, Henderson, was reelected Vice Speaker.

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1995-96 KMA year. Harry W. Carloss, MD, Paducah, was elected Chair, Board of Trustees, and Scott B. Scutchfield, MD, Danville, was elected Vice Chair. Donald R. Neel, MD, Owensboro, and Russell L. Travis, MD, Lexington, were named as Trustees-at-large.

It was noted that the KMA Executive Committee members also serve as the Board of Directors of KMA Physicians Services, Inc (KMA's holding company). The Board also made changes to the Kentucky Foundation for Medical Care Board of Directors in accordance with KFMC's Bylaws, and appointed KMA committees for the following year.

Five physicians were elected by the House of Delegates to serve on the 1996 Nominating Committee. Members elected were: Thomas R. Slabaugh, MD, Lexington, Chair; Susan G. Bornstein, MD, Louisville; John T. Burch, MD, Bowling Green; Charles G. Nichols, MD, Pikeville; Charles T. Watson, MD, Ashland.

Second Meeting, December 13-14, 1995

The KMA Board of Trustees met on December 13-14, 1995, at the Oxmoor

Country Club in Louisville. The Board members heard routine reports of the President; Secretary-Treasurer; Senior Delegate to AMA; Alliance President; Associate Dean, University of Louisville School of Medicine; Chair, KEMPAC Board of Directors; Commissioner for Health Services; and Board of Medical Licensure.

A special presentation was given by representatives of KMIC regarding its merger with Michigan Physicians Mutual Liability Company.

Detailed reports were given on activities of the Joint Oversight Group on Health Care Reform and the Committees on National and State Legislative Activities.

Appointments were made to the KMIC Board, and selections were made for submission to the Governor for appointments to the Hemophilia Advisory Board and the Kentucky Tobacco Research Board.

In further action, the Board adopted mission statements for the newly appointed Statewide Health Information Network Feasibility Study Committee and the Interspecialty Council. In response to Reference Committee No. 4 (1995), the Board recommended that the Health Policy Board set up an insurance ombudsman for patients to contact for unresolved problems with their insurance company or HMO.

Legal Counsel updated the Board on current legal activities during an executive session.

Additional reports were given by the Committee on Public Education, the KMA Hospital Medical Staff Section, and the Physician Organization Study Committee. In addition, a membership report was presented.

It was noted that the 1996 Annual Meeting will be held in Louisville with the new weekend format. The theme for the 1996 meeting is "Quality Care in an Age of Efficiency."

Third Meeting, February 7, 1996

A special called meeting of the KMA Board of Trustees was held on Wednesday, February 7, 1996, at Frankfort Country Club, to discuss Governor Patton's proposed legislative health care package. Lieutenant Governor Stephen L. Henry, MD, presented the Governor's plan to the Board.

After the Lieutenant Governor's comments and discussion by the Board, the Board reaffirmed Resolution B, as adopted by the 1992 House of Delegates, which outlined the Association's state legislative policies and authorized the Legislative Quick Action Committee to establish legislative positions determined to be in the best interest of the Association and its membership.

Fourth Meeting, March 3, 1996

The KMA Board of Trustees met in special session Sunday, March 3, 1996, at the Hyatt Regency Hotel in Louisville, to discuss the business that would come before the Special Session of the House of Delegates, scheduled to meet in one hour. Additionally, the Board adopted Resolution B, Legislative Policy, for presentation to the House of Delegates during the Special Session.

Fifth Meeting, April 17-18, 1996

The KMA Board of Trustees met in regular session on April 17-18, 1996, at Oxmoor Country Club in Louisville. The Board members heard reports from the President; Secretary-Treasurer; Alliance President; Dean, University of Kentucky College of Medicine; Board of Medical Licensure; Chair, KEMPAC Board of Directors; Senior Delegate to the AMA; and the Commissioner, Bureau of Health Services.

An extensive report was presented summarizing activities during the 1996 Kentucky General Assembly; and the Board heard presentations from Lieutenant Governor Steve Henry, MD, and Secretary of Health Services John Morse focusing on physicians' concerns with UNISYS and Medicaid claims.

The Board adopted the budget for fiscal year 1996-97, and the Sponsorship Agreement between KMA and the KMA Insurance Agency, Inc. In further action, the Board appointed a member and alternate to serve on the SB 137 Advisory Board as requested by the Department of Agriculture; selected nominees for service on the Kentucky Board of Medical Licensure; and approved plans for the new headquarters office.

Legal Counsel updated the Board on current legal activities regarding the Medicaid lawsuit settlement.

Additional reports were given by the Ad Hoc Committee to Study Guidelines for Prescribing Controlled Substances, the Physician Organization Study Committee, the Interspecialty Council, the Committee on National Legislative Activities, the Public Education Committee, the Committee on Physical Education and Medical Aspects of Sports, and the Committee on Medical Insurance and Prepayment Plans.



Sixth Meeting, June 20, 1996

The sixth meeting of the Board of Trustees was a special called meeting on June 20, 1996, to hear a proposal for KMA to establish a physician-directed preferred provider organization. Preferred Health Choice, an organization that has set up similar PPOs, made a presentation covering its experience and KMA's role in such a PPO. Reports were given concerning earlier discussions of this subject through KMA's Physician Organization Study Committee and the Executive Committee.

After considerable discussion, the Board noted that a statewide PPO was indicated to maintain some semblance of physician control. A number of recommendations were made for actions to be conducted by KMA to prepare KMA for a final approval vote by the House of Delegates.

It was reported that the next meeting of the Board would be August 14-15, 1996.

Seventh Meeting, August 14-15, 1996

The KMA Board of Trustees held its seventh meeting of the association year on August 14-15 at the Oxmoor Country Club in Louisville. Reports were presented by the President; Secretary-Treasurer; President, KMA Alliance; Senior Delegate to the AMA; President, Kentucky Board of Medical Licensure; Commissioner, Bureau for Health Services; and Chairman, Kentucky Medical Insurance Company.

In addition, considerable time was allotted to presentations by the Lieutenant Governor, Commissioner of Insurance, and a representative of UNISYS. The discussions centered on Medicaid reimbursement, managed care, KMA's lawsuit, health care reform, and rate hearings and other insurance matters.

Reports were given on various aspects of a KMA-sponsored statewide PPO and legal counsel reviewed documents pertinent to such. It was reported that with House of Delegates approval, finalization of the PPO should not take long.

The Board voted to continue the Legal Trust Fund voluntary assessment at \$25 and then heard committee reports on headquarters relocation, legislative activities, and KMA's health insurance plan. Reports were also given by the Public Education, Physician Workforce, Physician Organization Study, and ad hoc committees. A Judicial Council nominee was approved, Annual Meeting matters discussed, and six resolutions approved for presentation to the House of Delegates. Action was taken on each of some 40 committee reports, appointment of the KEMPAC Board of Directors made, and a final report presented by the outgoing KEMPAC chair.

In Executive Session, the Board named Mr William T. Applegate, KMA's Deputy Executive Vice President, to become the Executive Vice President on January 2, 1997, the date of Mr Cox's retirement.

The next three meetings of the Board were announced to be during the KMA Annual Meeting.

Executive Committee

The KMA Executive Committee meets between sessions of the full Board to guide the day-to-day operations of the association and to research and make recommendations to the Board of Trustees on issues of major concern. The Executive Committee is composed of eight officers and Trustees, and they met on eight occasions this past year. They are truly dedicated physicians.

Quick Action Committee

Four officers comprise the Quick Action Committee, namely the President, President-Elect, Chair of the Board, and Secretary-Treasurer. In addition, during legislative sessions like we had this year, our group also includes the Chair of our State Legislative Activities Committee and the Immediate Past President. The QAC met formally 14 times, each Wednesday evening in Frankfort during the session of the Kentucky General Assembly. The meetings lasted from about 4:00 pm until 9:00 pm. Members were traveling from the far end of the state; they worked hard, usually arriving early to visit legislators; and then returned home late at night. I thanked them frequently. Every member should do so too.

Ad Hoc Committees

There were four ad hoc committees of the Board working on projects this year.

The Ad Hoc Committee on KMA Headquarters, chaired by William B. Monnig, MD, completed its work after studying our future headquarters needs for the past couple of years. As a result, KMA will move into a brand

new building with space designed for our needs next month, October 18, 1996. The building, to be named The KMA Building, is located on Brownsboro Road in Louisville.

The Ad Hoc Committee to Study Guidelines for Prescribing Controlled Substances, chaired by E. C. Seeley, MD, was appointed to make a study and advise the Board of Medical Licensure on such guidelines. The committee completed its work on this seven-page document and one-page summary and emphasized to the Board that these are indeed guidelines and are to assist physicians in safe and appropriate decision making in prescribing controlled substances. The guidelines were printed in full in the August issue of the *KMA Journal*.

The Ad Hoc Committee to Develop a Comprehensive School Health Education Plan, chaired by Thomas L. Young, MD, will continue its activities next year. The committee has met with appropriate government officials and communicated with physicians and other health groups in seeking our goal of a plan to teach health education from kindergarten through the twelfth grade. This detailed report is available and the committee is confident we will eventually prevail as we continue to seek our goal.

The Ad Hoc Committee to Study the Composition of the Board of Trustees, chaired by Donald R. Stephens, MD, will also continue its work next year. The committee is looking into the Board structure, role of students, residents, etc and the House of Delegates structure, use of specialty representation, etc. The AMA's Study of the Federation is now ongoing and will make changes in representation at the AMA level. It was felt our committee should see the results of the AMA study, as well as seek more input at the state level. The committee is scheduled to do this and report back to the Board of Trustees next August.

Closing Comments

Again, I thank all the committee chairs, members, Board and officers, delegates and every member of KMA for your efforts this past year. Serving as your Chair has been a very special experience for me. I wish everyone had the opportunity to do so because you can see the real KMA from here and finally understand all the association does for us as physicians. Thank you for that privilege.

**Harry W. Carloss, MD
Chair**

Report of the Secretary-Treasurer

It is my pleasure to report to you as Secretary-Treasurer of the Association and to bring you greetings. This has been a particularly busy year for your organization and has brought many challenges to the profession.

We are pleased this year to welcome new Trustee Eugene H. Shively, MD, Campbellsville, representing the Fourth District; and Baretta M. Casey, MD, as a new Alternate Delegate to the AMA.

The business of the Association has kept apace with the demands of the membership and it has been gratifying to report that the fiscal state of KMA is strong. I will not address any details in this report but would invite the attention of the Delegates and the membership to the financial statements that have been made available to you. Details on the budget and related matters will be addressed in Reference Committee A during the meeting, and I invite your attendance, questions, and comments.

A major portion of KMA business this year has revolved around the office location. Working at the direction of the Headquarters Location Committee, we spent considerable time this year evaluating the building market in Louisville from both a building and renting perspective. After several months of searching, it was found that the land-purchase climate in the Louisville area was restricted, and land costs for sites suitable for our business were beyond our means. Many sites were reviewed in association with potential builders who offered several arrangements from outright purchase of the land, to lease/purchase of land and building.

It was concluded that building lease was the most appropriate course of action, and a number of sites offering the appropriate combination of location, cost, and adaptability to KMA's needs were considered. A final site was selected with the approval of the Executive Committee and the Board of Trustees which is located at 4965 US Highway 42 (Brownsboro Road). Contractual arrangements have now been completed, construction has begun on tenant modifications, and we have established a tentative move-in date of mid-October.

While this has been a very involved exercise, the new location is quite suitable to the needs of the Association, particularly because of adequate meeting space, which is lacking in the present location. The new offices will accommodate meetings of the Board of Trustees with sufficient space for two or three other simultaneous meetings. The location has convenient access to the Watterson Expressway (I-264) and is in a much less congested traffic area than our current site. Once this space is completed, I would encourage all members to make an effort to visit the offices.

After detailed and deliberate negotiations, the merger of the Kentucky Medical Insurance Company with the Michigan Physicians Mutual Liability Company was finalized in December 1995, and became effective January 1 of this year. Transition into the new corporate structure has occurred with minimal difficulties. As the controlling stockholder of KMIC, KMA realized benefits from the merger in the form of secure and continued availability of liability insurance to Kentucky physicians, and some economic benefit from its majority interest. Details of this issue can also be found in the financial reports you have received. Further information is available from any of the officers and can be discussed in Reference Committee A.

As many know, the Legal Trust Fund was depleted, primarily for legal services devoted to the Medicaid provider tax suit and related issues. Last year's contribution per member to the Legal Trust Fund of \$25 and the special voluntary assessment kept the fund solvent. However, the Board of Trustees has felt it prudent to accumulate sufficient funds for tentative and unanticipated legal matters that may arise. To this end, the Legal Trust Fund contribution for this year has again been established at \$25.

A very significant business issue of the Association is the retirement at the end of this year of Robert G. Cox, our Executive Vice President, after over 35 years of service. It has been my privilege to work with Bob Cox probably more closely than any other member or officer, and we have established an excellent relationship, both professionally and personally. I have had the benefit of being associated with Bob through countless hours of intense business evaluations and negotiations relating to the new office, as well as other routine business activities. His abilities as a steward for our organization and its financial management are simply unsurpassed, in my view. With his retirement, KMA will lose an extremely valuable asset and a good man. With deepest regards, I wish him an enjoyable and much-deserved retirement and my best wishes as a friend.

William T. Applegate, the current Deputy Executive Vice President, has been named the Executive Vice President Designate by the Board. With over 28 years of experience at KMA, Bill is possessed with the dedication, experience, and ability to guide our organization. Bill has been as closely involved as anyone in the management activities of KMA during my tenure. I have complete confidence in his talents and look forward to working with him as the new chief executive.

This has been a most challenging year for me, personally, and I sincerely appreciate the trust placed in me and my service.

William P. VonderHaar, MD
Secretary-Treasurer

Report of the Editor

The Journal of the Kentucky Medical Association remains an important link in the chain that binds KMA members together as doctors, whatever their specialty; it promotes dialogue among physicians about the practice of medicine in Kentucky.

The Journal Editorial Board adheres to the educational standards originally enacted in the Constitution and Bylaws of the Kentucky Medical Association by upholding a commitment to science and education. Publishing relevant articles and pertinent information to meet the constantly changing needs in health care is our top priority.

Your Editorial Board is a hard-working group of physicians who make their contributions freely and are paid nothing for the time and effort they expend on *The Journal*. I tip my hat to Drs Daniel W. Varga, Scientific Editor; Stephen Z. Smith, Assistant Scientific Editor; Martha Keeney Heyburn; Milton F. Miller; Jaroslav P. Stulc, and Carolyn D. Burns, Assistant Editors. Dr Burns, a pathologist, joined the Board in September 1995 and is the newest member of our team. She has stepped into her editor's role with obvious dedication and an invigorating enthusiasm. In 1995, professional obligations necessitated the resignation of Assistant Editor Jannice O. Aaron, MD, a member

of the Board since 1990. *The Journal* appreciates the contributions made by Dr Aaron.

The Board brainstorms and analyzes to present *Journal* articles that are timely, useful, and well written. There were 12 Editorial Board meetings during 1995, and of the 46 manuscripts reviewed (all unsolicited), the editors rejected 6 and returned 11 with recommendations for revisions, indicating a 63% acceptance rate.

During 1995, *The Journal* featured 21 original scientific articles representing the efforts of 63 authors and 3 Grand Rounds contributions from the University of Louisville School of Medicine representing 6 authors. Through 13 articles contributed by 31 authors, *The Journal* published a rich variety of socioeconomic information on academic trends, advancing technology, legal service, and other pertinent issues.

Additional features during the year included publication of the Interprofessional Code for the Kentucky Medical Association and the Kentucky Bar Association; a complete preliminary program for the 1995 Annual Meeting, as well as the entire proceedings of that meeting; several insightful contributions by Book Review Author Stephen Z. Smith, MD; Alliance updates; a special article from the Maternal Mortality Committee; and numerous editorials and letters discussing medical issues of interests to our readers.

With the May issue, *The Journal* was pleased to introduce "Monitoring Medicine, News for Kentucky Physicians," which has proven to be effective in supplementing the Association's reporting mechanisms by providing membership with the most recent developments in Frankfort and Washington, along with events and decisions which directly affect our patients and the profession.

The advent of managed care has led to a drastic decline in advertising targeted for doctors. Drug and equipment companies continue to direct their advertising monies away from doctors as they seek larger audiences and quick returns on investment. This trend does not favor state publications. Nevertheless, our local advertising is somewhat gratifying, and we continue to attract new ads through widespread use of media kits.

The cost of *The Journal* has been significantly controlled by prudent negotiation on contracts, changes in paper, and increases in subscription and advertising rates. Recently, there has been some relief in paper cost, which has skyrocketed for the past few years.

We wish to thank you, the readers of our magazine. You inspire us and we appreciate your feedback. We are interested in your comments, both positive and negative, and encourage you to contact us at any time.

A. Evan Overstreet, MD

Report of the Delegates to AMA

The Delegates to the American Medical Association were privileged to again represent the views of this Association and Kentucky physicians this year.

For your information, the KMA Delegation to the AMA now consists of five Delegates and five Alternate Delegates elected by the KMA House of Delegates. Delegate strength is determined on the basis of the number of AMA members in Kentucky. The AMA House of Delegates meets twice each year — in December at its Annual Meeting, and in June at its Interim Meeting.

At these meetings reference committee hearings are held two days, and there are ten reference committees. A member of the KMA Delegation is assigned routinely and continuously to each of these committees. The AMA House meets two or three days during these meetings for approximately nine hours a day. The KMA group meets separately during AMA meetings on each day that the House of Delegates meets to form consensus on issues and coordinate votes.

Routinely, the regular delegation is augmented by other participants from Kentucky. The AMA Organized Medical Staff Section has a separate two-day meeting preceding the AMA meeting, and the KMA Organized Medical Staff Section Delegates usually attend that meeting, as well as the regular AMA meeting on your behalf. In addition, there are contingents from the KMA Young Physicians Sections, the KMA Resident Physicians Section, and the KMA Medical Student Section.

Kentucky has been fortunate to gain several important seats at the AMA level. As many of you know, AMA Delegate Robert R. Goodin, MD, of



Louisville, was elected to a seat on the AMA Council on Medical Education at a special election last December. This year, William B. Monnig, MD, a KMA Alternate Delegate, was elected Secretary of the Governing Council of the Organized Medical Staff Section, having just completed a term as a member of that Council. In June this year Judy Linger, MD, completed her term as chair of the AMA Resident Physicians Section. Bruce Scott, MD, a Young Physicians Section Delegate, was elected to the Young Physicians Section Delegate position to the AMA House of Delegates after having served as a member of the AMA-YPS Governing Council. Ardis Hoven, MD, a Delegate, serves on the Group Practice Advisory Committee of the AMA, and this year served as a member of a special reference committee on two occasions to study one of the major issues occupying the attention of the AMA House.

At each meeting, the House of Delegates considers several reports of committees and councils, as well as reports of the Board of Trustees, and numerous resolutions. This material literally constitutes approximately 4½ inches of paper. Consequently, the issues dealt with are far too numerous to practically address here, but consideration of a few highlights is appropriate.

Approximately two years ago the AMA Council on Long-Range Planning proposed that a study be conducted to improve the effectiveness of the Federation on behalf of all physicians. A special study committee met to determine what could be done to make the Federation of Medicine more functionally effective and looked at possible changes in the organization of the Federation structure to make improvements. As the result of this work, the AMA Board of Trustees issued a report containing 34 recommendations based on the premise that the Federation could be restructured so that each component — county, state, national, and specialty — would retain its individual identity and activities, but would function together as a total enterprise to better serve all physicians.

Dr Hoven, as mentioned, sat on a special reference committee that considered this issue in December 1995, and again at the last meeting in June. A major controversy of this work was the allocation of Delegates between state and specialty societies. This work is ongoing to this date, and will continue for the next few years. Your delegation will attempt to keep you informed of these changes and what effect they may have on your own Association. The key issues yet to be determined are: how many Delegates medical specialty groups should be allowed to choose, how these Delegates will be elected, and how other special interest groups can be solicited and urged to participate in the AMA.

Another major issue addressed by the House in June was revision of the Resource Based Relative Value Study for Medicare payment purposes. In 1994, Congress mandated that the RBRVS instituted in 1992 be revised to update the practice cost component. The RBRVS is composed of physician work, practice cost, and liability insurance cost values. To make this update, the Health Care Financing Administration contracted for a survey of 5,000 physicians' offices. As of June 1, this survey had not been completed; 1,700 replies had been received. Because the level of response was not adequate according to the Office of Management and Budget, HCFA will be required to update the practice cost component extrapolating data from the surveys received.

There was a long discussion at the AMA meeting. The polar points were that if the incomplete survey data is used to update the RBRVS system, it would perpetuate flaws already acknowledged, and revisions to the RBRVS should not be implemented until valid data is available. The opposing view was that the current data be used and refined or revised if found to be inaccurate. A subissue was that if the current figures are used, primary care specialties would realize a 6-9% increase in payment, and surgery and other subspecialties would realize a 5-30% decrease. The AMA House finally agreed to call for a delay in use of the data until the contractor could accumulate valid information, which would occur in May 1997. The theoretical implementation date would then be postponed until mid-1998. Under the current situation, postponement past January 1, 1998, would require congressional action, and Congressman Ed Whitfield of Kentucky, together with Congressman Ralph Hall (D-TX), have introduced HR 3859 calling for a one-year extension. It is unknown whether or not these activities will be rendered moot when Congress begins consideration of general Medicare reform following the presidential election.

Because of the many other numerous and important issues considered that are not addressed here, your delegation would urge contact by any member having questions or concerns.

On behalf of the AMA delegation, we sincerely appreciate the opportunity to serve you and feel privileged to take part in the direction of organized medicine.

Donald C. Barton, MD
Senior Delegate

Report of the Executive Vice President

Effective January 2, 1997, I shall retire from the Kentucky Medical Association. In July 1961 I joined the staff of KMA, and except for a brief active tour in the US Army during the Berlin Crisis, KMA has been my work home. In March 1968, while staffing KMA's Washington Dinner, an emergency telephone call notified me of the sudden death of my predecessor, Mr Joseph Sanford. On April 17, 1968, the KMA Board of Trustees appointed me as chief executive officer of the KMA. In those 35 years, eight US presidents, 10 Kentucky Governors, 18 regular sessions of the Kentucky General Assembly, and 36 KMA Presidents and Board of Trustees have made my life exciting.

During these 35 years, the practice of medicine, as it always does, has gone through tumultuous change. While this final report will not enumerate nor document all the changes, it is appropriate to point out a few of them.

The most profound change in Kentucky has been the tremendous increase in the number of physicians. Until the mid 1980s, one of KMA's foremost goals was to assist communities in recruiting physicians. While pockets still exist in isolated areas, we now face an oversupply of physicians. Another major change has occurred as a result of the polar division between physicians and health insurance companies. Managed care has succeeded in temporarily making physicians "the third party."

The third and most dramatic change has occurred in the patient/physician relationship. We are not that far removed from a time when patients dutifully and "patiently" accepted without reservation physicians' recommendations. Two intervenors, trial lawyers and the information age, combined to place barriers on the patient/physician relationship. On the home-front, the emergence of the Kentucky General Assembly as Kentucky's major political power, which had traditionally been controlled by the Governor, has impacted KMA's entire approach to the Kentucky political scene. Finally, the most dominant issue has been the escalating — almost uncontrollable — rise in health costs.

As I reminisced over these 35 years, it became clear that each decade had its own identity as it related to the delivery of medical care. In the 1960s, with the advent of Medicare and Medicaid and the growth of workers' compensation, government for the first time became a major player in the delivery of health care. The 1970s could be best characterized as a decade of litigation and battles between legislators and trial lawyers over tort reform. The 1980s were totally dominated by rocketing health costs. The 1990s, at least through 1996, appear to be a decade in which health insurers, through managed care, have gained control and replaced the provider and government which traditionally regulated medical care.

Just as the environment in which we operate has undergone tremendous change, so has the KMA. While we have been a conservative organization by nature, we have also been on the cutting edge of change. We were the originators of the key legislative contact system; KMA established the original rural medical scholarship fund; KEMPAC was one of the early business/medical political action committees; KMIC was one of the pioneers of physician-owned insurance companies; and numerous original health and safety legislative proposals originated in KMA committees. Our handbook on sports medicine, and brochures on child, adult, and spousal abuse placed Kentucky at the forefront in dealing with major social issues. The idea of hospital signs on the US Interstate system originated in a KMA committee meeting, and was brought to reality for us by Senator John Sherman Cooper.

In addition, KenPAC, the first gatekeeper approach to the US to managing Medicaid patients, was originated by KMA and Kentucky's Cabinet for Human Resources; the Kentucky Physicians Care Program was the first program of its kind in the US and has received practically every award possible for its humanity and innovation in caring for the poor. We started other business ventures, such as an insurance agency, a credit union, and a computer company. Some did well — some did not.

In the early days, we could usually pick and choose our fights and

establish our own agenda. Most of our efforts were expended in patient oriented issues, and we were generally considered a public-minded organization. The major political battles were taking place in Washington, and on the state scene, KMA was one of the top four power players in Frankfort.

The 1970s, dominated by the malpractice insurance crisis, ultimately changed the Association and its direction forever. We took on a problem — the malpractice insurance crisis — and created an opportunity by forming the Kentucky Medical Insurance Company. From that fateful day in 1978 when the KMA Board of Trustees, operating on faith with minimal capital resources, formed KMIC, we have witnessed 18 years whereby the professional liability insurance crisis has been relatively abated, liability insurance is readily available, and the market is competitive. Whether physicians are insured by KMIC or by any of the other fine competitors, every physician has benefited by the birth of KMIC.

This year, perhaps reluctantly but wisely, we agreed to the sale of KMIC to a Michigan physician-owned company. We found that serving two masters — stockholders vs conservative liability rates for our insureds, was incompatible. Consequently, we decided to do what was best for our physicians and return to a physician-owned and managed company, while strengthening our financial clout by pursuing strong regional companies.

The men and women who have led KMA have been a source of pride for all of us who staff your Association. Each KMA Board member, Delegate to the House of Delegates, and committee member has contributed mightily to the Association; and by extension, every physician and patient in the Commonwealth. All of them have served unselfishly, at considerable personal and financial sacrifice, to develop programs and evaluate proposals that eventually benefit all members and their patients.

Like most of you, I enjoy my job and am delighted with my career choice. The job has been demanding, requires lots of night and weekend work, and a tough hide. The heart and soul of this position, though, is dealing with people. In that regard I have had the pleasure of working with second- and occasionally third-generation physician families, and in the process have grown up with many of you. The Association has been my life, where practically all my friends and acquaintances have evolved from my position at KMA. This did not happen by accident, for I have attempted to prepare this Association for tomorrow — whatever it brings. By associating with those who I believed were most knowledgeable, it has been mutually beneficial not to me personally, but more importantly, to the long-range goals of this Association. In my opinion, contacts with, and relationships with our allies, whether friends or occasionally foes, are crucial to survival.

While each of us has grown, so has the Association in the last 28 years. Shortly after I assumed the CEO mantle of KMA, active membership stood at 2,267, and KMA had a total reserve fund of \$45,066. On June 30, 1996, our active membership stood at 4,181 members and we have reserves of \$5,618,000. Our total assets in this same timeframe have risen from \$444,620 to \$6,802,806. Our 1996 budget for expenses was \$107,326, and that had risen to \$2,435,000 by June 30, 1996.

Our staff level has remained rather constant. In 1980 we had 25 employees, of whom 23 were full-time. Sixteen years later we have 24 staff members, and 22 are full-time. Much credit goes to the Board of Trustees for this amazing statistic. The Board, Executive Committee, and particularly the Budget Committee, have consistently permitted us to purchase the best and most modern office equipment and supplies, which has allowed us to be innovative in areas that support our overall staff performance and ability to communicate effectively with membership.

The KMA moved into its first "owned" headquarters office in Ephraim McDowell Drive in 1961. That building was remodeled several times and two major building additions were added; the first in 1972, and the last 10,000 square foot addition was completed in 1983. In 1991, short of space for our insurance company, we sold the old headquarters home and moved to the Office Forum on Hurstbourne Parkway. On October 15 of this year we will move to a new office on Brownsboro Road that should enhance our effectiveness in terms of location, and, with additional meeting space, will permit our Board of Trustees and other larger committees to once again find a home at the headquarters office.

When it comes to the Kentucky Medical Association, one constant has always been there — before, during, and following my departure — the staff. The physicians of Kentucky are truly blessed with outstanding staff members who possess a work ethic and a sense of pride in what they do and for whom they work. Their dedication to the medical profession and

to your patients is exemplified every single day by some individual action or assistance by one of these self-motivated individuals.

While I do not wish to dwell upon any talent God may have given me to enable me to carry out assigned responsibilities, the one single trait I think exists has been the foresight to recognize and recruit good people. If there is a legacy from Bob Cox to the KMA it is those people who have worked side by side with me for these many years. Whatever success I have had, they have had! You have a well-educated, competent staff that is recognized throughout the US as one of the most efficient and effective. I acknowledge and commend them for their outstanding work and continuing efforts.

The present staff has a total of 292 years of experience at KMA, which I believe to be a key component to our effectiveness and ability to absorb more and more responsibility. I leave believing that your future is secure and that KMA will continue to prosper, and the services and contributions to you as members will be significant.

While we have enjoyed enormous success over the years and have accomplished most of our objectives, all is not rosy. There are clouds on the horizon and obstacles being raised every day that can impede unity within the profession. I would submit to you four issues that lurk out there which have the capacity to make the Association's life miserable and threaten its effectiveness.

First, the growth of managed care has certainly impacted every physician, or soon will. For the first time, physicians are pitted against one another and the power of the greenback has the usual capacity to create evil and weaken the profession. The power struggle among physicians is already underway — a struggle for patients; and in some cases and in some areas — a battle for survival. Yet in these contentious times when physicians are pitted against one another, we must never yield to internal sabotage.

Second, beware of the Kentucky General Assembly. The 138 members of the General Assembly will ultimately determine your fate. We have already planned and are setting into place various legislative and political programs to respond to the legislative, political, and ethical reforms that have been adopted. Individual physician participation in the political process, particularly with elected state Representatives and Senators, is crucial to the profession's survival. The provider tax and HB 250, and our bitter and expensive struggle to overcome them, are firsthand witnesses to the need for physicians, spouses, and staff to get involved. Please do so.

The third concern is the growing animosity and divisiveness within the federation of medicine — county, state, AMA, and specialty groups — over which group best serves the physicians. While I do not have answers to this enigma, my 35 years of experience tells me that if 30 to 50 different groups are striving separately to influence the powers that be, then medicine is in hot water. There is a role for each of us, and if our best interest truly lies in serving the profession, then we will remain unified. On the other hand, if the goal is to perpetuate an individual or specific component of medicine, then the future is cloudy. In Kentucky, we have avoided power struggles, and our relationships, particularly with county and specialty groups, have been tremendous. We have only occasionally had minor differences with specialty groups over legislative positions, and they have always been worked out quickly and quietly.

I fear, however, for the future of AMA, our national body, and the one group that can truly represent all of medicine. Membership in the American Medical Association has declined to such an extent that AMA now represents only 44% of physicians. Those who gloat over this statistic have little understanding of the bitter fruits of AMA's plight, and how it has the potential to impact on our professional lives and all of us in the public and political arena. History is a reminder of what happens when a house becomes divided and selfishness rules the day.

My final and greatest concern is the tendency of young physicians to not join all segments of medicine. We must find new ways, and continue our efforts to bring young physicians into the body of medicine. The tremendous changes in medical school enrollment and graduation in which 50% of the classes are now female presents new challenges to a staid profession that has traditionally geared itself to the male physician. Young physicians are prone to work for others, rather than "hanging out the shingle." We need to vigorously and forcefully communicate the responsibility incumbent on young physicians to "continue the quest" for the survival of the profession. Physicians have an invaluable legacy to maintain the standards of medicine



and preserve them for future generations. This requires vigilance and resistance to programs that negatively affect patients.

When President Eisenhower left office he warned this country of the potential threats of the "Military Industrial Complex." As I leave, I would like to paraphrase Eisenhower's statement by admonishing physicians to beware the "Medical Corporate Complex." Reduction of costs is their motivation and profits alone their ultimate goal.

Patients must never be relegated to second-class medical care at the whim of some dark shadow at the other end of a telephone line, nor should they be treated as chattel. If third-party payors or government choose this route, so be it. Physicians, though, have a higher calling — a calling which impels them to refuse to participate in schemes which profit from placing obstacles to medical care access and marginal patient care.

This is my 28th and final report to you as the Association's CEO. I would refer you to the various committee, ad hoc, officer, and Board reports which detail our 1995-96 activities. Permit me to close with a heartfelt thanks to each of you for the marvelous opportunity you have given to me. While I have chosen not to name names in this report (it would have taken up too much space, plus I would have forgotten someone special), there are obviously physicians and spouses out there, many who passed this way long ago, who played a splendid part in whatever success I have enjoyed. You know who you are, and I am sincerely thankful for you and your friendship. Kay and I now leave to enjoy our family, play a few rounds of golf, and spend some time with old friends.

Several years ago a member of the staff picked up a "Coxism" and made sure it was never forgotten or discarded. That famous "Coxism" simply states, "Nothing replaces preparation, unless it's cancellation." The statement speaks for itself and fairly well defined my philosophy; it served me well through the years. Establishing goals, preparation, and the will to succeed and make the plan work are not new survival tactics or keys to success. Just plan your work and work your plan. As staff, we try to reflect your stature and your prestige in all we do.

You have the staff, the ethics, and the people power to continue the brilliant 145-year history of this Association. I close with an anonymous quotation — "What ought to be, can be, if you have the will to make it go."

Thank you for giving me the privilege of serving as your Executive Vice President.

Robert G. Cox
Executive Vice President

Report of KMA Physicians Services, Inc

KMA Physicians Services, Inc, is the only wholly-owned subsidiary of the Kentucky Medical Association, and serves as a holding company to its own subsidiary, the KMA Building Corporation.

The KMA Building Corporation was dissolved on August 29. It was formed when we owned our own building, but now that we have just signed a ten-year lease for a new headquarters, the Building Corporation is no longer needed.

Since KMA Physicians Services, Inc, is a for-profit subsidiary, we are currently keeping it active. The rapid changes taking place in medicine today could well call for such an organization on short notice. The KMA Executive Committees serves as its Board of Directors.

Harry W. Carlross, MD
Chair

Report of the Kentucky Medical Insurance Company

Kentucky Medical Insurance Company's performance in 1995 and through the first five months of 1996 has been outstanding. Highlights include considerable improvement in financial performance. New endorsements are being awarded and new business is increasing every day. This success is showcased by the January 1, 1996, merger with Michigan Physicians Mutual Liability Company (MPMLC). MPMLC's similarity to KMIC is almost uncanny. Both organizations are sponsored by their respective state medical associations. Both organizations focus on financial strength, and both are governed by a board of directors made up of health care professionals. Even more importantly, both companies share the same guiding principles: commit-

ment and service to physicians and health care institutions. Together, KMIC and MPMLC insure over 7,000 physicians and health care institutions and represents over \$550 million in total assets.

Highlights

KMIC's outstanding performance began with a solid 1995 foundation. For the year ending December 31, 1995, net income was up 57% to \$749,629 from \$478,242 for 1994. Total revenues for 1995 were \$18.3 million, compared with \$17.8 million the previous year. Also, total assets increased by 5%.

The company's strong financial performance is continuing. Through May 30, 1996, net income is up 138% to \$539,105 from \$226,625 the previous May. Revenues are up to \$12.9 million, compared to \$12.5 a year ago. Total assets increased 5% since May 1995.

In the marketing arena, KMIC's introduction of workers' compensation is underway. This new entry into the marketplace is a strategic step in KMIC's long-term success. KMIC has also introduced a provider stop-loss product for capitated programs. Renewals for 1996 are currently at 91%.

A.M. Best's rate of A- (excellent) for KMIC was reaffirmed this July. The company has held this rating for four years now, which is particularly gratifying because many other medical liability insurance companies have recently been downgraded by A.M. Best.

Growth in the Ohio market continues. KMIC has quoted many millions in new business in Ohio and, thus far, has secured 429 policyholders (or about \$2.3 million in premiums) in Ohio.

Risk management services have been expanded, and the company is offering 12 new programs during 1996.

By working in tandem with Michigan Physicians, KMIC is seeking economies, sharing product knowledge, and expanding services.

Claims

| | 1995 | 1994 |
|--------------------|-------------|-------------|
| New Claims | 309 | 249 |
| Claims Closed: | | |
| with payment | 68 | 70 |
| without payment | 156 | 190 |
| Not Indemnity Paid | \$7 million | \$8 million |
| Cases to Trial | 43 | 46 |
| Cases Won | 33 | 41 |

Although the number of claims closed with payment remained almost constant between 1994 and 1995, net indemnity paid in 1995 was down significantly. KMIC remains concerned, however, about the rise in frequency and continues to monitor this trend in 1996.

Through May 1996, KMIC has had 77 claims closed without payment, compared to 55 over the same period in 1995. Indemnity paid through May 1996 was \$3.1 million, compared to \$4.0 million through May 1995.

Future Opportunities

KMIC will continue to focus on building additional alliances and strategic partnerships. Growth is essential to serve the future medical liability insurance market. KMIC's progress in 1995-1996 has been nothing short of outstanding. As the company prepares for the 21st century, it will continue to set a precedent for excellence in the medical liability insurance arena.

Richard F. Hench, MD
Chair

Report of the Ephraim McDowell Cambus-Kenneth Foundation, Inc

The Ephraim McDowell Cambus-Kenneth Foundation, was incorporated on May 26, 1988, as a not-for-profit Kentucky corporation and exists exclusively for "charitable and education purposes in promoting an appreciation of history through the acquisition, restoration, and preservation of buildings and properties having special historic significance."

The Foundation was formed by the Kentucky Medical Association for the purpose of accepting from Mr Joe A. Wallace and Mrs Cecil Dulin Wallace, upon their deaths, the 550-acre Cambus-Kenneth Farm located in Danville. As many of you know, Mr Wallace passed away in late 1992. Today, the Farm remains with Mrs Wallace, recipient of the 1993 KMA Award. The Cambus-Kenneth Farm was owned at one time by the pioneer physician, Ephraim McDowell, MD; served as his summer home; and was

the site of his death. Additionally, the assets of the former McDowell Memorial Fund, including the McDowell House and Apothecary Shop, also located in Danville, were conveyed to the Foundation by the Kentucky Medical Association.

The Foundation's Board of Directors met in September 1995, and re-elected the following corporate officers for 1995-96: Robert R. Goodin, MD, President; and William P. VonderHaar, MD, to a combined office of Vice-President and Secretary-Treasurer. Other members of the Foundation Board include John W. McClellan, MD; Scott B. Scutchfield, MD; G. Russell Shearer, MD; and David W. Kinnaird, MD, as an ex-officio member. At this meeting, the Foundation Board of Directors formally declined the gift of the Cambus-Kenneth Farm from Mrs Wallace due to previously unforeseen restrictions placed upon the Foundation's acceptance of the Farm.

The McDowell House Managers Committee operates under the auspices of the Foundation to supervise the maintenance and operation of the McDowell House and Apothecary Shop. A report on the financial status of the McDowell House will be presented to the Foundation's Board of Directors at its annual meeting in September. However, finances seem to be in good order. The Managers Committee is placing additional emphasis on the "Friends of the McDowell House" project in an attempt to increase the number of Friends and to increase financial gifts to the McDowell House.

The Kentucky Medical Association Alliance has continued to play an important role in maintaining and adding to the collection of the McDowell House and has been very faithful in its participation.

The Foundation Board would like to thank Russell Shearer, MD, Chair of the McDowell House Managers Committee, as well as the Committee members, McDowell House staff, and volunteers who have made the operation of the Foundation a success during the last year. I would also like to express my personal appreciation to the other members of the Foundation Board for their service during this past year.

**Robert R. Goodin, MD
President**

END OF CONSENT CALENDAR ITEMS

Report of the Physician Advisory Committee to Health Kentucky (Health Care Access Foundation)

The Physician Advisory Committee to Health Kentucky serves as a resource to the foundation regarding issues affecting Kentucky Physicians Care. KMA has three physician members on Health Kentucky, Donald C. Barton, MD, who serves as Vice-President; Ardis D. Hoven, MD; and Salem M. George, MD. Because of the physician input to the Health Kentucky Board, it has not been necessary for the Advisory Committee to meet this year. However, we do remain available for consultation.

KMA approved Kentucky Physicians Care in September 1984 and the program was implemented January 1, 1985. Since the program began, 159,109 calls have been made to the 800 number by clients asking for referrals or for information on applying for the program. Currently, 2,249 physicians participate in the program. A total of 68,523 referrals have been made throughout the program's existence. Once patients are in the system they usually do not call back for a follow-up visit authorization. The physician usually sees them and follow-up is routine. Similarly, referrals to non-primary care physicians usually take place without going through the referral process. The services of hospital-based specialists are not reflected in the referral numbers, either, since most of these services are coordinated through the attending physician once the patient is hospitalized. Thus, it is reasonable to assume that the number of patient/physician encounters as a result of KPC is far greater than the 68,523 logged referrals. The committee believes an estimated ratio of four encounters per referral may be low, but it would equate to about 275,000 free encounters for the 154,144 individuals who are certified for the program over its existence.

In addition to KMA's participation, there are 100 participating Kentucky hospitals. Three hundred and four participating dentists have had 4,525 referrals since 1991. A total of 43,721 free prescriptions have been filled by 431 participating pharmacists since 1990. An unknown number of free home health care and Hospice services have been provided as well. Clearly, this project has been extremely successful and serves as a model for similar programs across the country to this day.

Two years ago, overall program responsibility for Kentucky Physicians Care was transferred from KMA to Health Kentucky, the foundation which oversees the coordination of the entire access program. The committee feels that this change has been positive and no problems concerning the physician component of the program have been reported.

Last year, the committee, in conjunction with Health Kentucky, recognized participating physicians by sending a letter of appreciation to participants, commending their participation and thanking them for providing this extremely valuable service to the citizens of Kentucky.

Health Kentucky reports that software used by the Kentucky Physicians Care Referral Program has been updated and will provide greater capability for future data analysis concerning both applicants and volunteer providers. Plans are also under way to evaluate data which has been collected over the first ten years of operation and another study is planned to determine what affect the program has had on reducing visits to emergency departments.

As in the past, the committee continues to believe that the program is very worthwhile and serves a useful purpose providing a conduit for individuals to primary physician services. For that reason, the Committee recommends:

1. KMA continue its endorsement of the Health Kentucky goal of increasing access to care for Kentucky's less fortunate citizens.
2. KMA encourage all Kentucky physicians to continue to voluntarily participate in Kentucky Physicians Care to the extent possible.
3. KMA continue its endorsement of Health Kentucky contingent on:
 - a. Program funding being continued, as appropriate, by Health Kentucky.
 - b. A continuing commitment from the Cabinet for Human Resources to evaluate the program applicants for eligibility as is currently done.
 - c. The other participating provider groups maintaining the same or increased level of participation in the foundation program.
 - d. Health Kentucky making documented efforts to vigorously encourage the participation of all other health care delivery and/or financing organizations in the foundation's program, as may be appropriate.
 - e. Health Kentucky making documented efforts to make Kentucky legislators and the general public aware of the plight of those ineligible for Medicaid assistance, solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

I appreciate the continued interest and participation of the members of the Advisory Committee and am most grateful for the generosity of the physicians in this state who continue to give so generously and freely of their services.

**Russell L. Travis, MD
Chair**

RECOMMENDATIONS:

1. KMA continue its endorsement of the Health Kentucky goal of increasing access to care for Kentucky's less fortunate citizens.
2. KMA encourage all Kentucky physicians to continue to voluntarily participate in Kentucky Physicians Care to the extent possible.
3. KMA continue its endorsement of Health Kentucky contingent on:
 - a. Program funding being continued, as appropriate, by Health Kentucky.
 - b. A continuing commitment from the Cabinet for Human Resources to evaluate the program applicants for eligibility as is currently done.
 - c. The other participating provider groups maintaining the same or increased level of participation in the foundation program.
 - d. Health Kentucky making documented efforts to vigorously encourage the participation of all other health care delivery and/or financing organizations in the foundation's program, as may be appropriate.
 - e. Health Kentucky making documented efforts to make Kentucky legislators and the general public aware of the plight of those ineligible for Medicaid assistance, solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.



Recommendations, Reference Committee A:

Reference Committee A reviewed the Report of the Physician Advisory Committee to Health Kentucky and recommends that the report and its Recommendations be adopted.

RESOLUTION 96-103

Benefits of Membership in Organized Medicine

Board of Trustees

WHEREAS, as a result of KMA's public, political, and legislative campaign, the Governor and the Kentucky General Assembly agreed to repeal the provider tax; and

WHEREAS, even though the provider tax is being repealed incrementally, 6,000 Kentucky physicians will pay on the average \$1,750 less provider tax in 1996-97; and

WHEREAS, after intense lobbying and negotiation Governor Paul Patton and members of the Kentucky General Assembly leadership increased physician Medicaid reimbursement by \$26 million annually with an average accrual to each Kentucky physician in the amount of \$4,300; and

WHEREAS, as direct consequence of a lawsuit filed in federal court by KMA against the Commonwealth of Kentucky, state government has agreed to retroactively reimburse Kentucky physicians a one-time \$52 million payment which if averaged among 6,000 actively practicing physicians amounts to a payment of \$8,650; and

WHEREAS, as a corollary to an enormous undertaking by 4,200 dedicated KMA members who financed a three-year, three-quarters of a million dollar public relations, legal, and legislative campaign, the average physician, both member and nonmember, will receive an estimated \$14,700 resulting from KMA member dedication; now, therefore be it

RESOLVED, that this House of Delegates congratulates the KMA Legislative Committee, KMA Public Education Committee, KEMPAC, and individual physician members for a significant victory; and be it further

RESOLVED, that the 1996 KMA House of Delegates encourages nonmembers to join, and become actively participating members of their county society, state association, and AMA so that the profession, as a deliberative and unified body, can continue to resist any egregious regulation or law which does not act in the best interest of our patients and the practice of medicine.

Recommendations, Reference Committee A:

The Reference Committee reviewed Resolution 103, Membership in the Federation, introduced by the Board of Trustees.

Reference Committee A heard testimony from representatives of the Board of Trustees and notes that the title of the resolution was changed by the author to "Benefits of Membership in Organized Medicine." Reference Committee A recommends adoption of Resolution 103.

RESOLUTION 96-112

AMA Federation Study

Jefferson County Medical Society

WHEREAS, the Study of the Federation has embarked on an ambitious effort to "reinvent" the Federation of Organized Medicine into a more inclusive, more relevant, and more cost-effective network of professional associations; and

WHEREAS, the recommendations of the Federation Study will make the AMA more representative of a broader base of physician members; and

WHEREAS, the Federation Coordinating Team will develop pilot projects to test new ideas for greater collaboration and teamwork among segments of the federation; now, therefore, be it

RESOLVED, that the Kentucky Medical Association reaffirm the findings of the Federation Study and actively support physician membership at all levels of organized medicine.

Recommendations, Reference Committee A:

Reference Committee A considered Resolution 112, the AMA Federation Study, introduced by the Jefferson County Medical Society.

The reference committee recommends that the Resolved of the resolution

be amended by substituting the word "intent" for "findings." The amended Resolved would then read as follows:

RESOLVED, that the Kentucky Medical Association reaffirm the findings intent of the Federation Study and actively support physician membership at all levels of organized medicine.

Reference Committee A recommends that Resolution 112 be adopted as amended.

RESOLUTION 96-118

Repeal of Kentucky Certificate of Need Law Franklin County Medical Society

WHEREAS, the Certificate of Need (CON) process has been totally ineffective in reducing medical costs; and

WHEREAS, CON now serves only to create monopolies in some communities and restrains competition for the medical dollar; and

WHEREAS, outpatient services have been shown to be cost and quality effective and are increasingly the major source of health care delivery in the US; now, therefore be it

RESOLVED, that the Kentucky Medical Association supports the repeal of Kentucky's Certificate of Need Law.

Recommendations, Reference Committee A:

The Reference Committee reviewed Resolution 118, Repeal of Kentucky Certificate of Need Law, introduced by the Franklin County Medical Society.

After hearing extensive testimony, the Reference Committee concluded that while there was general agreement with the sentiments for improvement or elimination of the CON process, the issue is not a simple one. The Certificate of Need question is already under consideration by the Board of Trustees in a number of different contexts; it is therefore the recommendation of the reference committee that Resolution 118 be referred to the Board of Trustees for further discussion.

RESOLUTION 96-124

Physician Representation by Organized Medicine Fayette County Medical Society

WHEREAS, many physicians' practices are merging, being acquired by clinics, or purchased by corporate health care entities; and

WHEREAS, corporations may offer representation of physicians' interests but may fail to make doctor needs a true priority; and

WHEREAS, academic institutions benefit from organized medicine activities yet participate with membership in Kentucky as low as 27%; and

WHEREAS, academic boards advocate physician representation but subjugate it to institutional need; and

WHEREAS, organized medicine — county, state, and national — remains the strongest and most effective spokesperson for physicians; now, therefore be it

RESOLVED, that the Kentucky Medical Association urge doctors in all medical groups, managed care organizations, and academic institutions to join and participate in organized medicine in order to preserve a unified and broad-based voice that focuses on physician priorities in health care; and be it further

RESOLVED, that KMA encourage medical boards and their corporate directors to support financially and underwrite membership in all levels of organized medicine.

Recommendations, Reference Committee A:

Reference Committee A reviewed Resolution 124, Physician Representation by Organized Medicine, introduced by the Fayette County Medical Society.

After extensive discussion with members of the Fayette County Medical Society, it was determined that the intent of the resolution was to encourage physicians, larger corporate health care entities, and academic institutions to support participation in organized medical societies. Reference Committee A therefore recommended that the Resolveds of the resolution be changed by addition & deletion as follows:

RESOLVED, that the Kentucky Medical Association urge doctors in all

medical groups, managed care organizations and academic institutions to join and participate in organized medicine in order to preserve a unified and broad based voice that focuses on patient advocacy and therefore physician priorities in health care; and be it further

RESOLVED, that KMA encourage medical boards and their incorporated corporate health care entities and their directors to financially support and underwrite membership in all levels of organized medicine.

The reference committee recommends that Resolution 124 be adopted as amended.

[Subsequently, during the break in House proceedings, John D. Stewart, II, MD, noted that the phrase "to financially support" is a split infinitive, and the Speaker agreed that the correct wording would be "to support financially" and approved this grammatical correction.]

Resolution 124, adopted as amended, reads as follows:

RESOLUTION 96-124

Physician Representation by Organized Medicine Fayette County Medical Society

WHEREAS, many physicians' practices are merging, being acquired by clinics, or purchased by corporate health care entities; and

WHEREAS, corporations may offer representation of physicians' interests but may fail to make doctor needs a true priority; and

WHEREAS, academic institutions benefit from organized medicine activities yet participate with membership in Kentucky as low as 27%; and

WHEREAS, academic boards advocate physician representation but subjugate it to institutional need; and

WHEREAS, organized medicine — county, state, and national — remains the strongest and most effective spokesperson for physicians; now, therefore, be it

RESOLVED, that the Kentucky Medical Association urge doctors in all medical groups, managed care organizations, and academic institutions to join and participate in organized medicine in order to preserve a unified and broad-based voice that focuses on physician priorities in health care; and be it further

RESOLVED, that KMA encourage corporate health care entities and their directors to support financially and underwrite membership in all levels of organized medicine.

RESOLUTION 96-128

School Health Examinations Board of Trustees

WHEREAS, the Kentucky Department of Education (DOE) has, as of August 1, 1996, supported recommendations from the Local Superintendents Advisory Council that school examinations need not be recorded on the approved forms which have been used in the past, if the document used provides the required information; and

WHEREAS, this has resulted in the Department of Education modifying existing regulations (704KAR4: 020 [sec 2] and 704 KAR4: 0020 [sec 5]) which could thus allow numerous versions of examination forms to be used on a school system-by-school system basis; and

WHEREAS, examiners may then have to contend with filling out multiple unfamiliar forms causing delays in the performance of routine exams and confusion in record keeping; now, therefore, be it

RESOLVED, that the KMA House of Delegates go on record as supporting standardized DOE forms as the accepted forms for school examinations and student athletic examinations and discourage the use of multiple forms which vary in format from the approved DOE forms; and be it further

RESOLVED, that the KMA offer to work with the Kentucky Department of Education to refine and adjust these standardized forms as necessary to insure that these forms are succinct and accurate.

Recommendations, Reference Committee A:

Reference Committee A considered Resolution 128, School Health Examinations, introduced by the Board of Trustees.

After hearing testimony from members of the Board of Trustees Refer-

ence Committee A recommends that the two Resolveds be combined into a single Resolved to read as follows:

RESOLVED, that the KMA work with the Kentucky Department of Education to develop a set of forms for school examinations and student athletic examinations that will be considered an acceptable alternative in all Kentucky school districts and discourage the use of multiple forms.

The Reference Committee recommends that Resolution 128 be adopted as amended.

Mr Speaker, Reference Committee A recommends the adoption of this report as a whole.

Mr Speaker, I want to thank the members of Reference Committee A who worked hard to assist the House of Delegates on these matters. Other members of the committee were: Joseph J. Dobner, MD, Frankfort; K. Thomas Reichard, MD, Louisville; Bruce A. Scott, MD, Louisville; John D. Stewart, II, MD, Lexington; and David J. Zoeller, MD, Elizabethtown. I also wish to thank Ms. Carol Rowe for her help and guidance in preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE A
Mohan K. Rao, MD, Madisonville, Chair
Joseph J. Dobner, MD, Frankfort
K. Thomas Reichard, MD, Louisville
Bruce A. Scott, MD, Louisville
John D. Stewart, II, MD, Lexington
David J. Zoeller, MD, Elizabethtown

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE B

William D. Pratt, MD, London, Chair

14. Report of the Scientific Program Committee
15. Report of the Scientific Exhibits Committee
16. Report of the Continuing Medical Education Committee
17. Report of the Council for Continuing Medical Education
18. Report of the Cancer Committee
19. Report of the Physician Workforce Committee
20. Report of the Organized Medical Staff Section
21. Report of the Rural Kentucky Medical Scholarship Fund

Resolution 101 — Laboratory Accreditation

(Nancy Swikert, MD, President, KAFP)

Resolution 102 — New Kentucky Medical School
(Board of Trustees)

Resolution 111 — Licensure for Telemedicine
(Jefferson County Medical Society)

Resolution 119 — Mandated Information for Women Diagnosed with Breast Cancer
(Jefferson County Medical Society)

Resolution 125 — Pap Smear as a "Clinical" Laboratory Test
(Fayette County Medical Society)

ITEMS FOR CONSENT

Reference Committee B reviewed the following items and recommends they be filed, by consent of the House, without discussion:

16. Report of the Continuing Medical Education Committee — filed
17. Report of the Council for Continuing Medical Education — filed

Mr Speaker, Reference Committee B recommends adoption of the Consent Calendar as a whole.



Report of the Continuing Medical Education Committee

The work of the Continuing Medical Education Committee continues to see expanding activity. The committee met on a quarterly basis this year and held its annual seminar on the continuing medical education accreditation process on May 23, 1996. Since the promulgation of mandatory continuing medical education for physicians as a condition of licensure, the activity of the committee has increased as the number of organizations which the committee accredits as providers of continuing medical education continues to expand. As a result, the committee conducted numerous surveys and resurveys of institutions which applied for accreditation of their CME programs. The committee serves as the accreditation arm of KMA's CME efforts. In this role, the committee assists organizations in developing effective CME programs and then monitors organizations' programs through formal surveys. After the surveys, the committee, in most cases, grants accreditation to organizations so they can, in turn, conduct individual CME programs. Due to the increase in accredited sponsors, the committee would like to encourage additional KMA members to take an active interest in the proceedings of the committee and assist in accreditation efforts by serving as site team surveyors.

Surveys were conducted for five institutions which had applied for reaccreditation. One organization applying for reaccreditation was approved and granted an accreditation period of four years based on its ability to meet the criteria of the KMA Essentials, which all organizations must demonstrate to become accredited. Three organizations were given a three-year accreditation period, and one organization was granted probationary status. In addition to the resurveys of previously accredited organizations, four new organizations submitted applications and were granted surveys. All four applicants were approved and granted up to a two-year provisional accreditation period, with an interim report to be filed at the midpoint of the accreditation cycle.

The initial accreditation process assumes six steps. First, an organization submits a preliminary questionnaire to the KMA Headquarters Office. When the preliminary questionnaire is deemed appropriate, the organization submits an application to the KMA; the survey team then reviews the application and determines if the organization is ready for a survey; a survey is conducted; the survey team formulates a survey report with suggestions for improvement to the organization, as well as a recommendation regarding the accreditation period to the CME Committee; and the survey report is subsequently voted on by the committee as a whole. After the committee approves an accreditation status, it notifies the organization and informs the organization of the accreditation period. The reapplication process is essentially the same format without the preliminary questionnaire. The committee also requires an interim report from the organization at the midpoint of the accreditation period so the committee can continue to monitor and assist the organization between surveys.

The CME Committee continues to implement the suggestions of the ACCME, including: mailing a CME newsletter to all accredited organizations on a quarterly basis; accrediting organizations up to four years for full accreditation and first-time applicants up to two years; offering a consultation service if organizations need additional assistance in establishing a CME program; and offering an expanded seminar with breakout sessions for different tracks based on the knowledge level of CME personnel in Kentucky.

One new policy implemented this year by the committee was the encouragement of the formation of a consortium. The committee noted that due to the changing nature of the health care delivery system, health care organizations are looking into mergers and buyouts to consolidate services and make health care delivery more efficient. Because the KMA accredits organizations to provide continuing medical education, KMA encourages two or more organizations in geographic proximity who are able to work together to apply as one organization to provide CME to area physicians.

The committee continues to update its CME recordkeeping folder which allows physicians licensed in Kentucky to keep track of continuing medical education credits earned during the year. The folder is mailed to all KMA member physicians on an annual basis.

The committee continues to have input at the national level regarding CME. Robert R. Goodin, MD, updates the committee regularly on the business of the AMA Council on Medical Education, on which he won a position

through a special election at the AMA Interim Meeting in December 1995. Dr Goodin reported to the committee at its regular meeting in May on the changes taking place at the ACCME, on which Dr Goodin serves as a Board member. Dr Goodin noted that the ACCME is in a time of transition in an attempt to restructure the Essentials as well as the recognition activities of state medical associations. The ACCME is attempting to develop a more "user-friendly" approach to its accreditation activities and encourage organizations to look at the outcome of the educational activity so as to determine if the activity was of value. The push for the new system stems from the changing nature of health delivery.

Physician educators want to teach physicians the best way to care for patients through seminars, conferences, didactic lectures, etc, that makes the most efficient use of physicians' time, as well as having a positive impact on physicians' practices. The CME Committee will stay abreast of the ACCME transition, and it will make appropriate changes at the state level as requested by the ACCME.

The committee continued its annual solicitation for nominees for the Educational Achievement Award. Since the committee revised the criteria and the selection process four years ago, the number of nominations has increased annually. Seven nominations were received and considered by the committee. One recipient was selected by the committee. The recipient was Frank B. Miller, MD, a Louisville surgeon.

The committee continues to oversee the implementation of Resolution J from the 1992 House of Delegates on mandatory CME for physicians as a condition of licensure. The resolution was considered by the Kentucky Board of Medical Licensure, implemented into a regulation on mandatory CME for physicians in October 1993, and became effective on January 1, 1994, with the beginning of the annual license renewal period for physicians. The regulation requires that all licensed Kentucky physicians obtain 60 hours of continuing medical education credits within a three-year period. Of the 60 hours, 30 of the hours must be in Category 1 credit, and 2 hours must be obtained from a Cabinet for Human Resources-approved HIV/AIDS Training Course. The committee will continue to monitor the regulation and forward information to the Kentucky Board of Medical Licensure if any changes are undertaken that would affect the nature of CME.

The committee held its annual accreditation process seminar on the Essentials on May 23, 1996. The seminar was attended by over 60 people who serve as CME chairpersons and directors of CME from across Kentucky.

Attendees heard discussions on "CME and Quality Assurance — Creating a Link for Improved Outcomes," "CME Leadership," "Restructuring the Essentials: An Update from the ACCME," "A Needs Assessment Overview," "The CME Office," "Joint Sponsorship," and "Using Commercial Companies as a Resource." The seminar is a popular avenue for CME coordinators to meet and discuss common issues and learn from each other, as well as the various speakers.

As a result of increased initiatives by the CME Committee to assist organizations in maintaining quality continuing medical education programs in Kentucky, expenses have escalated. The committee revised its fee structure to intrastate accredited organizations in order to simplify the budgeting process and meet increased fees required by the ACCME. The committee increased the initial application fee, discontinued the resurvey fee, and increased the annual fee accordingly. This way organizations can budget for the annual fee without having to pay a resurvey fee which sometimes occurs in the same year.

The committee has an additional meeting scheduled for September and anticipates another busy year in 1996-97.

Thomas K. Slabaugh, MD
Chair

Report of the Council on Continuing Medical Education

The Council on Continuing Medical Education met on two occasions this year, with both meetings held jointly with the CME Committee.

Since the Council on Continuing Medical Education serves as the provider of CME for the Association, it focuses much of its efforts on the Annual Scientific Program. The council reviewed the theme, "Quality Care in an Age of Efficiency," and the draft of the program for the 1996 KMA Annual

Meeting from the work of the Scientific Program Committee. The council reviewed evaluation forms from the 1995 Annual Scientific Session, as well as 1996 Scientific Program speakers, topics, and objectives.

The council is accredited by the Accreditation Council on Continuing Medical Education (ACCME) to provide continuing medical education for physicians in Kentucky. The council was granted a four-year reaccreditation by the ACCME in October, which signified that the KMA was continuing to provide quality education programs and installing various improvements as recommended by the ACCME. The updates which led to the new four-year accreditation status included a revision of the mission statement, revision of the policy on joint sponsorship, and designation of CME credit for programs of the KMA other than the Scientific Program of the Annual Meeting. In its application to the ACCME, the council noted that better efforts are being made at needs assessment, development of learning objectives, and documentation of all phases of the planning steps as required under the "ACCME Essentials and Guidelines of Continuing Medical Education." In addition, all appropriate forms are used in acceptance of commercial support for programs as required under the "ACCME Standards for Commercial Support."

The council, having revised its joint sponsorship policy, jointly sponsored several programs this past year. With mandatory CME for physicians as a condition of licensure in place, the council has seen an increase in requests for joint sponsorship which allows nonaccredited organizations to have CME credit designated for their educational programs.

The council approved a need from the Kentucky Academy of Eye Physicians and Surgeons to jointly sponsor its program in June. The program was attended by over 50 physicians and the evaluations indicated that the program was well planned and presented.

The council received a request from Cardiovascular Associates and approved the need to jointly sponsor its annual symposium in October. The symposium attracted over 120 physicians and the evaluations indicated that the speakers were of high quality and the objectives of the program were met.

Finally, the CME Council worked with the Kentucky Society of Anesthesiologists to plan and present its program in April. Over 60 physicians attended a well-planned program designated for 11 hours of CME credit. The evaluation forms showed positive reviews of the educational content.

The council worked with different committees of the Association to plan and designate educational activities for AMA PRA Category 1 credit. The Committee on State Legislative Activities (COSLA) of the Association submitted a need to the council to hold a seminar on legislative issues pertinent to physicians' offices. After assessing an appropriate need for the seminar, the council assisted in planning the program with representatives of the Committee on State Legislative Activities and designated the seminar for one hour of Category 1 credit. Fifteen seminars throughout the state were attended by over 1,000 physicians, and physicians noted that the seminar was integral in helping them understand the pending legislative issues which were to be considered by the 1996 Kentucky General Assembly.

Although serving as site surveyors for organizations accredited by the KMA is not the responsibility of the Council on Continuing Medical Education, most members of the council volunteered their time and served as site surveyors for organizations submitting applications for accreditation under the auspices of the CME Committee. Serving as a site surveyor is an effective way to stay current on the accreditation process as well as oversee the important steps of the Essentials that all organizations, including the KMA, must maintain in planning continuing medical education activities. The CME Council will also work closely with the CME Committee to sponsor the annual "CME Accreditation Process Seminar" which was held in May and attended by over 60 people involved in continuing medical education across the Commonwealth.

During the coming year, the council will continue to judiciously address requests for joint sponsorship from nonaccredited organizations, and will work to fulfill the recommendations of the ACCME to maintain a high level of quality continuing medical education offerings in Kentucky.

The council would like to thank the Board of Trustees for being permitted to serve, and looks forward to expanded activity in 1996-97.

James L. Borders, MD
Chair

END OF CONSENT CALENDAR ITEMS

Report of the Scientific Program Committee

"Quality Care in an Age of Efficiency" was selected by the Scientific Program Committee as the overall theme for the 1996 KMA Annual Meeting Scientific Program. Each morning session will focus on the theme from the perspective of the various specialties participating in the meeting. The committee members and representatives of the planning committee from the 23 specialty societies have worked hard to bring some of the United States' top speakers to the meeting, and it is hoped that the membership will find their presentations practical and helpful.

The Scientific Program was planned last fall and a meeting was held in December with the presidents and/or representatives of the 23 specialty groups that will participate in the annual session. Specialty groups' scientific programs held in conjunction with the morning general sessions have proven to be very popular, and provide an excellent source to the continuing medical education of the membership. I personally appreciate the excellent cooperation the committee has had from all of the specialty societies in planning the overall meeting, and I thank them for their suggestions and assistance, and encourage them to continue to assist the committee in finding new and innovative ideas for topic selection and presentation.

The 1995 Annual Meeting was held at the Hyatt Regency Hotel/Civic Center in Lexington, Kentucky, with an attendance of 2,059 total attendees.

Exhibitors were asked to fill out evaluation forms on Tuesday, Wednesday, and Thursday during the 1995 meeting. This allowed a better assessment of exhibitors' viewpoints and new ideas which they may have for improving the meeting to be considered by the Scientific Program Committee. The exhibitors' comments were, overall, positive.

Results from physicians' evaluation forms from the general sessions and specialty group meetings were again positive and revealed that physicians attended the 1995 Annual Meeting program because of the availability of Category 1 CME credit, a friendly learning environment, speaker quality, and the overall program content.

The Kentucky Medical Insurance Company will again sponsor a Risk Management Workshop for Office Assistants, as well as a separate workshop for physicians.

The 1996 KMA Annual Meeting will be held at the Hyatt Regency Hotel/Commonwealth Convention Center in Louisville. Meetings of the KMA Board of Trustees, House of Delegates, reference committees, KEMPAC, and Alliance, as well as various food functions, will be held in the Hyatt Regency Hotel. General registration, specialty group meetings, general sessions, and the technical exhibit hall, as well as scientific and education exhibits, will be located in the Convention Center. We urge members and their staffs to visit the exhibits. These informal contacts offer numerous opportunities, education reviews, and discussion of new products and familiarization with new equipment, free from the interruptions or distractions of the office or hospital.

This will be the first year that the Annual Meeting will feature a weekend format. The General Sessions and specialty group meetings will be condensed into a two-day format on Friday and Saturday, which should allow physicians to travel to Louisville over the weekend and attend the education programs.

The scientific sessions are again designated for AMA PRA Category 1 continuing medical education credit and are also approved for prescribed credit by the American Academy of Family Physicians.

As always, I am very grateful for the efforts of all those individuals who have assisted in the formation of another outstanding program, particularly the Program Committee, specialty group presidents, and program chairs. Suggestions for future programs are always welcomed by the Scientific Program Committee.

James L. Borders, MD
Chair

Recommendations, Reference Committee B:

Reference Committee B reviewed the Report of the Scientific Program Committee. The Committee would like to commend James L. Borders, MD, for his hard work and service to the Scientific Program Committee. We would also like to commend the committee for its willingness to consider change in an attempt to improve attendance at the Annual Meeting. Reference Committee B recommends Report No. 14 be filed.



Report of the Scientific Exhibits Committee

Although the Scientific Exhibits Committee does not meet formally, the work that is put into the scientific exhibits area continues to be a strong component of the overall success of the Annual Scientific Meeting. The activities of the committee are carried out by mail and telephone. We notify members through the *Journal of the Kentucky Medical Association* and the *KMA Communicator* of the availability of space and provide applications to interested individuals. In 1995, five outstanding scientific exhibits were approved by the Scientific Exhibits Committee. We also provide exhibit space for entities such as the Impaired Physicians Program. We wish to express our appreciation to the following exhibitors at the 1995 Annual Meeting:

Kentucky Cancer Program

Ms Connie Sorrell

Undertreatment of Cancer Pain in America

Paul A. Soan, MD

Future Care for Alzheimer's Patients

William T. Ramage, MD

Surgical Management of Total Occlusion of Infrarenal Aorta

Sibu P. Saha, MD

Reflex Sympathetic Dystrophy

M. Mazloomdoost, MD

We would also like to congratulate "Undertreatment of Cancer Pain in America" which is the recipient of the 1995 Award of Excellence.

I want to take this opportunity to thank the members of the committee for their dedication in serving on the Scientific Exhibits Committee. The scientific exhibits area continues to be a significant and substantial portion for the exchange of necessary and practical scientific information at the Annual Scientific Meeting, and we feel that it is worth all physicians' time to stop at the scientific exhibits area during the Annual Meeting and visit with the scientific exhibitors.

Richard A. Kielar, MD
Chair

Recommendations, Reference Committee B

Mr Speaker, Reference Committee B reviewed the Report of the Scientific Exhibits Committee. The Reference Committee is very concerned about the small number of scientific exhibits. We would encourage the members of the Kentucky Medical Association to participate on a greater scale. Reference Committee B recommends that Report 15 be filed.

Report of the Cancer Committee

The Cancer Committee met on two occasions this year to address current concerns in the field of cancer treatment in Kentucky.

The committee continued its study on the number of radical and modified radical mastectomies being performed in Kentucky. In researching the rates, Gary Vitale, MD, and Mr Ray Shaheen, a fourth-year medical student, designed a questionnaire to use as a resource to see why patients were choosing mastectomies. The survey will be undertaken as a pilot project at Jewish Hospital, Norton Hospital, and Western Baptist Hospital on a small sample of patients so that a high response rate is achieved. The study is being done as a combined project of the Kentucky Medical Association, the University of Kentucky, and the University of Louisville.

The resources of the Kentucky Cancer Program are being utilized in the compilation of the data. The Kentucky Cancer Program is a joint effort of the cancer centers of the University of Kentucky and the University of Louisville, and has three divisions: the Cancer Information Service, Community Programs, and the Kentucky Cancer Registry. The three divisions function as a team to provide data-based information about cancer to the public and to health care professionals throughout the state. The mastectomy pilot study is scheduled for completion on September 1, 1996.

The committee reviewed the history and structure of the Kentucky Cancer Consortium as reported by Mr Greg Lawther, Manager, Adult Health Branch-Department for Health Services. In 1990, the Department received a grant from the National Cancer Institute to study cancer-related data in the state. The goal of the consortium was to develop a cancer control plan. In order to achieve the goals of the plan, four technical workgroups were established: the Access to State-of-the-Art Treatment Workgroup, Early Detection of Breast Cancer Workgroup, Early Detection of Cervical Cancer Work-

group, and the Tobacco Abatement Workgroup. The committee reviewed the progress concerning the priorities of each workgroup. The Kentucky Cancer Consortium requested the assistance of the Cancer Committee in several areas. In review of the results to date, the Cancer Committee has achieved the results which it was asked to accomplish by the Kentucky Cancer Consortium. In addition, to assist the State-of-the-Art Treatment Workgroup, the Cancer Committee recently compiled information on the radiation facilities in Kentucky and formulated a statewide map of those facilities so that the Department for Health Services would have a better understanding of where the facilities were located.

Mr Lawther also reported that the Adult Health Branch administers about 2.5 million dollars in funds that pay for breast and cervical cancer screening for low income women. This funding has been available since 1990. Additional funding comes from the Centers for Disease Control as part of the National Breast Cancer and Cervical Cancer Screening Program. A portion of the funding is used for public education and a portion for professional education. Future plans for the committee include exploring areas for physician training on educating women on breast and cervical cancer options.

The committee would also like to congratulate Gil Friedell, MD, a longstanding member of the Cancer Committee, for awards received this year. Dr Friedell received the Calum S. Muir Memorial Award for Outstanding Contributions in the Field of Cancer Registration from the North American Association of Central Cancer Registries. He also was awarded the Leffall/White Award for Cancer Prevention and Control Research in Underserved Populations by the American Association for Cancer Research and the Intercultural Cancer Council, and a Certificate of Appreciation by the American Cancer Society for his support of the creation of the Centers for Disease Control's National Program of Cancer Registries. Dr Friedell is Director of the nationally praised Kentucky Cancer Registry and co-directs the Kentucky Cancer Program. Congratulations go to Dr Friedell for a job well done.

The committee will continue its study and research into cancer issues at subsequent meetings. The committee looks forward to continued activity and would like to thank the Board for being permitted to serve.

Harry W. Carloss, MD, FACP
Chair

RECOMMENDATIONS, REFERENCE COMMITTEE B:

Reference Committee B reviewed the Report of the Cancer Committee and wishes to congratulate Gil Friedell, MD, on the awards he has received this year. Reference Committee B recommends the Report of the Cancer Committee be filed.

Report of the Physician Workforce Committee

The Physician Workforce Committee convened once this year to study various issues related to workforce such as physician supply, medical school and residency training, and physician choices of practice location.

The committee considered a study prepared by Carol L. Elam, EdD, Assistant Dean for Admissions, University of Kentucky. The study, "Geographic Origin and its Impact on Practice Location in Kentucky," examined which medical students from Kentucky are most likely to return to their geographic origins to practice medicine and the frequency with which this occurs.

Students admitted from 1974 through 1985 served as the study population so that data would be available on their practice locations subsequent to the completion of their residency programs. Matriculants' class year, age, gender, county of residence, undergraduate institution attended, cumulative undergraduate grade point averages, and Medical College Admissions Test (MCAT) scores were available from class characteristics on file in the admissions office.

It was reported that over the study period (1974-1985), 1,250 students matriculated at the University of Kentucky College of Medicine. Geographic data on site of residency training were available for 1,243 graduates, and practice locations were available for 1,093 physicians-in-practice. The average age of the study population at matriculation was 23.3 and 72.1% were male. Of those studied, 34% completed their undergraduate degrees at the University of Kentucky, 22% at Kentucky public universities, 15% at Kentucky private colleges or universities, and 29% at out-of-state colleges or universi-

ties. Over the study period, 92% of the matriculants were Kentucky residents. The average cumulative undergraduate GPA was 3.54. Of the study graduates, 51% entered primary care residency programs and 31% remained in Kentucky for their residency training. Of the physicians-in-practice for whom there were data (1,093), 42% were in primary care practices.

It was also noted that other physicians who stayed in-state, but did not return to their district of origin, tended to locate their practices in the district containing the study institution.

Review of the regression analysis indicated that commonly used preadmission factors related to age, gender, undergraduate institution attended, cumulative undergraduate GPA, MCAT score, and county of residence at matriculation explained only 8% of the variance in physician practice location. Expanding the model to include location of residency program and specialty choice contributed an additional 14% of the variance. The study noted that the majority of the variance in the predictive model was not explained. Therefore, it is doubtful that increasing the number of males accepted or increasing the number of admissions extended to students from particular counties or who have attended particular colleges and universities would dramatically impact the number of graduates staying in Kentucky and entering rural practice.

Combinations of professional, personal, sociocultural, and economic factors are well recognized as influencing physicians' practice location decisions. Admission officers and residency directors seeking to improve the ratio of graduates practicing in their home states should endeavor to devise new measures to assess the affinity for district-of-origin of our physicians in training. Measures which assess an applicant's attraction to positive aspects of rural medical practice or small town life may help determine those individuals most likely to opt to practice in rural areas. The committee acknowledged that this study is important to the work of admissions committees at the medical schools in selecting applicants who may be willing to go to rural areas to practice medicine.

The committee also looked at the development of a third Kentucky medical school. Recent press reports discuss the popularity of the idea of developing a third medical school in Kentucky. Specifically, community and business leaders in Pikeville, Kentucky, including the present Governor of Kentucky, Paul Patton, have voiced public support for adding a private osteopathic school to Pikeville College. The Physician Workforce Committee assessed various state and national physician workforce issues to be considered in the addition of a third medical school — public or private — in Kentucky.

The Kentucky Medical Association has addressed physician workforce issues in Kentucky since the mid-1980s. Over the course of the past decade, major changes in health care have prompted serious study in the total number of physicians and their distribution across the United States. National organizations, such as the Council on Graduate Medical Education, the PEW Commission, the American Medical Association, the Institute of Medicine, the Physician Payment Review Commission, and the American Association of Medical Colleges have all made recommendations for reducing the rapid growth in the physician workforce in the United States. This paper will discuss some of the recommendations of the aforementioned organizations regarding their physician workforce policy implications and their impact on the need for a third Kentucky medical school. In addition, this paper will address the current status of medical education in Kentucky, state funding of medical education, and the potential economic implications to the Commonwealth of adding a third medical school. The financing and delivery of health care in the United States are changing rapidly, and imbalances in the physician workforce remain highly relevant to those changes. The movement from fee-for-service coverage to capitation and the growth of integrated systems of managed health care profoundly affect requirements for the physician workforce, medical practice, and medical education.

The supply of active allopathic and osteopathic physicians has grown dramatically. From 1970 to 2000, the number of active physicians will increase from 156 to 261 per 100,000 members of the population, and the number of physicians in active patient care medicine will nearly double, from 115 to 203 per 100,000. The supply of physicians is projected by the Bureau of Health Professions of the Department of Health and Human Services to continue to outpace the growth of the population into the early 21st century. It is generally agreed that between 145 and 185 physicians in patient care per 100,000 per population is an appropriate ratio for a system

expected to be dominated by managed care early in the 21st century. The current supply of physicians already exceeds this estimated staffing requirement and further increases are inevitable over the next two decades unless there are major policy changes. Extensive analysis indicates that only by reducing the number of first-year residents to 110% (or less) of the current number of graduates of US medical schools—the equivalent of 6,000 fewer first-year residents enrolling each year—will the supply of physicians be brought into line with public need for physicians by 2010. This policy is supported by the Council on Graduate Medical Education, the PEW Commission, the Institute of Medicine, and the Physician Payment Review Commission.

While Kentucky's supply of physicians is less than the national average of physicians per 100,000 members of the population at 194, Kentucky still exceeds the estimated numbers needed for the future. In response to the oversupply of physicians, the medical schools at the University of Louisville and the University of Kentucky in 1982 voluntarily reduced their class sizes by 10%. In addition, with managed care prompting changes in the primary care/specialist ratio of physicians, the two Kentucky medical schools have boosted the number of medical students entering primary care residencies to above 50% for the past three consecutive years. It is evident by these numbers that the medical schools are answering the call to reduce the number of graduating physicians and meet the demands of the physician workforce by the year 2000, producing more primary care physicians. In fact, current projections indicate that the appropriate number of primary care physicians will be reached by the year 2000 by continuing present trends.

The issue of funding of a third public medical school in Kentucky gives rise to great concern. While a private school would not require money from the state budget, a third public medical school would put a great strain on the general budget should the state be forced to provide funding. Another question of clinical training comes up in adding a third medical school. While the University of Kentucky and University of Louisville medical schools do an outstanding job of teaching third and fourth-year medical students in urban and rural areas in the Commonwealth, there do not seem to be adequate sites left for quality teaching outside of the urban areas. Dr. Wayne Myers, Director of the University of Kentucky Center for Rural Health, states that rural medical schools can provide high-quality medical education to no more than 20 students per year, and this will inevitably lead to significant financial losses at the currently projected tuition rates. Once classes reach the size necessary to financially support a rural school, he said, the quality of teaching usually declines, "because there are not enough places nearby for students to receive really good clinical teaching."

Many authorities have speculated through the years that the way to get more physicians into rural areas is to attract physicians from rural areas and continue to train them in rural areas at various times during their medical school years. Several studies have demonstrated that one primary indicator of where physicians choose to practice depends on their residency location. Through studies of the Kentucky Physician Workforce Committee, several factors were shown to determine physician location of practice, including lifestyle, availability of quality education for children, location of family members, hometown of spouse, availability for consultation with other physicians, and residency location. In a recent study on Graduate Medical Education and Practice Location, by Seifer, et al, it was determined that nationwide, 51% of physicians practice in the state in which they obtained their graduate medical education. In conclusion, Seifer, et al, found that most physicians' training and practice locations function as a national market, with many physicians dispersing relatively widely after completing graduate medical education.

At present, a very high percentage of the qualified rural students in Kentucky who apply to our two public medical schools are accepted. It is highly unlikely that additional qualified rural students will be generated merely by the presence of a third medical school, especially if tuition costs, as projected, will run 250–300% of current public medical school tuition rates per year.

In conclusion, there are numerous state and national studies which go against the Commonwealth adding a third medical school, be it public or private. Nationally, both the American Medical Association and the American Osteopathic Association informally have separately and independently chosen to not advocate adding additional medical schools in the United States due to the current oversupply of physicians. If an additional medical



school was developed in Kentucky, the availability of physician instructors to provide quality clinical education for students would be in short supply in rural areas and there would be little guarantee of those students returning to Kentucky when their residency training is complete. In a study by Dr Carol Elam, et al, it was determined, in fact, that only 8% of Kentucky medical students who came from a rural area, went to high school in a rural area, attended a Kentucky medical school, and completed a Kentucky residency could safely be predicted to return to the area in which they were raised to practice medicine. In effect, the Kentucky Medical Association Physician Workforce Committee recommends that a careful study be undertaken regarding the need for additional medical school graduates in Kentucky before a third medical school is developed.

**Robert R. Goodin, MD
Chair**

Recommendations, Reference Committee B:

Reference Committee B reviewed the Report of the Physician Workforce Committee. Reference Committee B would like to commend Doctor Goodin for the work that he has done with this committee. We would like to stress that the particular indicators for determining those individuals who would embrace rural practice have not been identified. The committee felt that nonobjective factors, including educational and cultural resources, should be stressed as mentioned by Doctor Goodin in his report. This issue addressed by the Physician Workforce Committee is discussed in Resolution 102. Reference Committee B recommends that the Report of the Physician Workforce Committee be filed.

Report of the Organized Medical Staff Section

The KMA Organized Medical Staff Section (OMSS) worked this year to refine the focus of our section to meet some of the changing needs of the profession. At the 1995 Interim Meeting, the American Medical Association House of Delegates expanded the responsibilities of the Hospital Medical Staff Section to include the representation of the medical staffs in emerging delivery systems, to change the name of the old "Hospital" Medical Staff Section to the OMSS, and to restructure the representative body and redirect its mission and goals to more closely align with the needs and interests of constituent physicians.

The KMA-OMSS followed suit and proposed such changes to the Board of Trustees at its December 1995 meeting. Along with appropriate revisions to the OMSS Bylaws, the Board approved these changes. To accomplish these goals, the OMSS began work to develop a process and structure for significant physician involvement in managed care plans and emerging integrated medical delivery systems; to strengthen the medical staff's professional role for accountability of patient care and the integrity of the patient/physician relationship; and to continue to provide information, communication, and educational resources to medical staff physicians.

Vigorous efforts were made to increase involvement in the section through personal contacts by KMA-OMSS Executive Committee members, articles in the *Communicator*, and specific contacts with the medical staff of each hospital, health facility, and emerging delivery system in the Commonwealth. Each of those organizations is eligible to elect one voting Representative and one Alternate Representative to the KMA. Representatives must be KMA members in good standing with clinical privileges who are nominated and elected by members of an active, voting medical staff. In addition, the Chair and other members of the Executive Steering Committee were pleased to have the opportunity to speak at local hospital medical staff meetings to furnish information about our organization. A good deal of follow-up contact was made resulting from each of these solicitations, and we are hopeful that the ranks of the OMSS will continue to grow.

Nationally, members of the KMA section attend meetings of the AMA Organized Medical Staff Section, which meets prior to the regular meetings of the AMA House of Delegates. Routinely, 5-10 representatives from Kentucky are able to attend. The OMSS regularly submits approximately 50 resolutions and reports to the acting AMA House. In this respect, the OMSS acts as a separate, distinct body to transmit members' concerns directly to the AMA House. The AMA-OMSS meetings provide an excellent forum for the interchange of ideas among peers nationwide and an opportunity to receive crucial information on developments affecting our professional

status.

It is gratifying to note that at the national level one of Kentucky's own physicians, William B. Monnig, MD, is a successful, active leader. Dr Monnig previously won election to the AMA-OMSS Governing Council as a Member-At-Large, and at the past meeting in June was elected Secretary of the Council. Dr Monnig was a founding member of the KMA HMSS, and is a past president of our organization.

The KMA-OMSS Executive Committee is now in the process of finalizing plans for the OMSS annual meeting to be held October 25-26. Issues to be considered at that meeting will be hospital restructuring, hospital mergers, the development of integrated systems, the creation of physician organizations, and changing JCAHO requirements. Additional information on this meeting will be forthcoming, and the meeting will be open to all OMSS members and other interested physicians.

As Chair, I would like to thank the Board of Trustees for its support of our activities and the members of the OMSS Executive Committee for their support and efforts. We look forward to another challenging year as we identify and evaluate all of the influences on our professionalism occasioned by organized systems.

**John D. O'Brien, MD
Chair**

Recommendations, Reference Committee B:

Reference Committee B reviewed the Report of the Organized Medical Staff Section. Reference Committee B would like to encourage attendance at the Organized Medical Staff Section meeting which will be held October 25 and 26 at the Rudd Heart and Lung Building at Jewish Hospital. Reference Committee B recommends that Report 20 be filed.

Report of the Rural Kentucky Medical Scholarship Fund, Inc

The Rural Kentucky Medical Scholarship Fund, Inc. (RKMSF) attempts to meet the medical needs of the rural population by alleviating the maldistribution of physicians in Kentucky. RKMSF currently administers two worthwhile programs in its efforts to meet this goal.

The first program provides low interest loans to medical students. Any loan recipient who practices primary care medicine in a county in critical need of physicians will be forgiven one loan for each full year of practice in the approved county. Any recipients practicing in a designated rural county facing a primary care physician shortage which is less than critical must repay their loans at a discounted interest rate which is determined yearly. Interest accrues from the date of the loan until the loan is paid in full.

For the school term 1996-97, the RKMSF offered scholarship loans to 9 new applicants in the amount of \$12,000 each, and 10 loans to prior student recipients, said loans totaling \$228,000. Last year a total of \$170,000 was expended in scholarship loans. In 1994-95, \$190,000 was expended.

Since its inception in 1946, the Rural Kentucky Medical Scholarship Fund has granted approximately 630 loans. In 1996-97, 9 recipients are entering primary care residency programs, 18 recipients are currently enrolled in residency programs, and 5 recipients are entering the full-time practice of medicine in 1996. There were 4 recipients who received forgiveness of loans in 1995-96, and 5 recipients completed their financial and/or practice obligations in 1995-96.

The second program administered by RKMSF is the Establish Practice Grant Program (EPGP). The EPGP provides money to practicing physicians to assist in paying prior educational loans. For each year a physician in the EPGP practices in a critical county, they will be granted \$10,000 to be used toward an educational debt, with a maximum of \$40,000 granted per physician.

Two physicians are currently participating in the EPGP. Since its inception in 1989, there have been a total of 10 participants in the EPGP. Currently, there are 3 vacancies in the Establish Practice Grant Program.

The 1996-97 educational year brought some changes to the RKMSF. In an effort to make the Fund more competitive with existing marketplace loans and opportunities, the Board of Directors approved new critical/rural county designation identifiers which should add some stability to the county designation process. Under these changes, 45 counties will be designated

as critical and 40 as rural. Additionally, during 1996-97, the loan amount was increased from \$10,000 to \$12,000. It is hoped these changes will help the RKMSF continue to grow and comply with its mission statement of placing primary care physicians in underserved areas of Kentucky.

The RKMSF has two main sources of income: interest accrued on the scholarship notes which are paid back or bought out and interest on investments. The average maturity of RKMSF investments is just under 3½ years, with an average yield of 7.08%.

The Kentucky Medical Association continues to provide financial and other support to the RKMSF which greatly contributes to the success of the Fund. The RKMSF, while operated through the KMA, is a separate, nonprofit corporation, having its own officers and Board of Directors. This report is furnished as an informational item.

Donald R. Stephens, MD
Chair

Recommendations, Reference Committee B:

Reference Committee B reviewed the Report of the Rural Kentucky Medical Scholarship Fund. Reference Committee B would like to commend the Rural Kentucky Medical Scholarship Fund for its work. Reference Committee B would like to recommend that Report 21 be filed.

RESOLUTION 96-101

Laboratory Accreditation **Nancy Swikert, MD, President** **Kentucky Academy of Family Physicians**

WHEREAS, the Commission on Office Laboratory Accreditation (COLA) was founded by the American Academy of Family Physicians, the American Medical Association, the American Society of Internal Medicine, and the College of American Pathologists; and

WHEREAS, the Commission on Office Laboratory Accreditation is the only not-for-profit education and accreditation organization specifically designed to meet the needs of physician-directed laboratories that are practice-based; and

WHEREAS, demonstrating quality in the physician office setting is an integral part of the ever-evolving and competitive health care industry; and

WHEREAS, the accreditation program of the Commission on Office Laboratory Accreditation is a mark of excellence for health care practices poised to compete in today's dynamic health care marketplace; now, therefore, be it

RESOLVED, that the Kentucky Medical Association endorse the accreditation program for laboratories of the Commission on Office Laboratory Accreditation; and be it further

RESOLVED, that the Kentucky Medical Association publicize information about the Commission on Office Laboratory Accreditation and encourage physicians to seek laboratory accreditation through COLA as their mark of laboratory excellence and the professional alternative to federal certification under CLIA '88.

Recommendations, Reference Committee B:

Reference Committee B reviewed Resolution 101, Laboratory Accreditation. The committee recommends that the resolution be amended by deletion and by replacing the word "publicize" with the word "provide" in the last Resolved, which would then read:

RESOLVED, that KMA publicize provide information about the commission on office laboratory accreditation and encourage physicians to seek laboratory accreditation through COLA As their mark of laboratory excellence and the professional alternative to federal certification under CLIA '88.

Mr Speaker, Reference Committee B recommends the adoption of Resolution 101 as amended.

RESOLUTION 96-102

New Kentucky Medical School **Board of Trustees**

WHEREAS, the supply of actively practicing physicians in the United States is expected to double from 115 per 100,000 members of the population to 203 per 100,000 by the year 2000; and

WHEREAS, various studies have shown that new physicians generally locate in a region near their residency training; and

WHEREAS, an additional Kentucky medical school would place the Commonwealth near the top of medical school graduates per capita; and

WHEREAS, due to budget limitations and oversupply of physicians, the University of Louisville and University of Kentucky have voluntarily reduced their medical student class size by 10%; and

WHEREAS, should a third public medical school become reality, it would place an undue financial hardship on the budget of the Commonwealth of Kentucky; and

WHEREAS, the Council on Graduate Medical Education, the PEW Commission, the Institute of Medicine, and the Physician Payment Review Commission have all recommended a cap on the number of residency slots in the United States due to the oversupply of physicians; now, therefore, be it

RESOLVED, that the Kentucky Medical Association, along with the University of Louisville School of Medicine and the University of Kentucky College of Medicine, recommend that the Kentucky Council on Higher Education conduct an extensive study of the feasibility of an additional medical school, allopathic or osteopathic, private or public; and be it further

RESOLVED, that the KMA meet with Governor Paul Patton and interested individuals and groups to discuss the physician workforce needs of Kentucky; and be it further

RESOLVED, that the KMA report back to the 1997 House of Delegates on the progress of their study relating to the proposed private osteopathic school in Pike County.

Recommendations, Reference Committee B:

Reference Committee B reviewed the Resolution 102, New Kentucky Medical School. Reference Committee B recommends that it be amended by deleting the first and third Resolveds and substituting a new Resolved:

RESOLVED, that KMA oppose reallocation of human, financial and academic resources currently available for medical education toward an additional allopathic, osteopathic, public or private medical school.

Reference Committee B recommends that Resolution 102 be adopted as amended.

Resolution 102, adopted as amended, reads as follows:

RESOLUTION 96-102

New Kentucky Medical School **Board of Trustees**

WHEREAS, the supply of actively practicing physicians in the United States is expected to double from 115 per 100,000 members of the population to 203 per 100,000 by the year 2000; and

WHEREAS, various studies have shown that new physicians generally locate in a region near their residency training; and

WHEREAS, an additional Kentucky medical school would place the Commonwealth near the top of medical school graduates per capita; and

WHEREAS, due to budget limitations and oversupply of physicians, the University of Louisville and University of Kentucky have voluntarily reduced their medical student class size by 10%; and

WHEREAS, should a third public medical school become reality, it would place an undue financial hardship on the budget of the Commonwealth of Kentucky; and

WHEREAS, the Council on Graduate Medical Education, the PEW Commission, the Institute of Medicine, and the Physician Payment Review Commission have all recommended a cap on the number of residency slots in the United States due to the oversupply of physicians; now, therefore, be it

RESOLVED, that the KMA meet with Governor Paul Patton and interested individuals and groups to discuss the physician workforce needs of Kentucky; and be it further

RESOLVED, that KMA oppose reallocation of human, financial, and academic resources currently available for medical education toward an additional allopathic, osteopathic, public or private medical school.



RESOLUTION 96-111

Licensure for Telemedicine Jefferson County Medical Society

WHEREAS, "telemedicine" generally refers to the practice of medicine across distance via telecommunications and interactive video technology; and

WHEREAS, telemedicine has the potential to have positive impact on the cost and availability of some services pertaining to health care delivery and medical education; and

WHEREAS, at the same time, the growing application of telemedicine raises significant issues with respect to:

- confidentiality of patient information;
- degradation of quality by commercial misuse;
- development of practice guidelines;
- interstate licensure;
- professional liability; and
- coding/reimbursement; now, therefore, be it

RESOLVED, that the Kentucky Medical Association explore ways of developing licensure guidelines for telemedicine, consistent with efforts of the AMA now taking place in conjunction with the Federation of State Medical Boards; and be it further

RESOLVED, that the Committee on State Legislative Activities monitor the development of licensure guidelines for telemedicine, in order that the committee may be prepared to formulate a timely and appropriate KMA legislative position; and be it further

RESOLVED, that the KMA encourage pilot studies which include appropriate licensure mechanisms and reimbursement by third parties, in order to measure the efficacy and viability of telemedicine.

Recommendations, Reference Committee B:

Reference Committee B reviewed Resolution 111, Licensure for Telemedicine and recommends that it be amended by deletion of the third Resolved. Reference Committee B recommends Resolution 111 be adopted as amended.

RESOLUTION 96-119

Mandated Information for Women Diagnosed with Breast Cancer Jefferson County Medical Society

WHEREAS, KRS 311.935 currently mandates that women in the Commonwealth of Kentucky, upon receiving a diagnosis of breast cancer, must receive comprehensive information regarding surgical treatment options, chemotherapy, and radiation therapy; and

WHEREAS, recent scientific evidence demonstrates that psychosocial counseling promotes increased longevity and a higher quality of life; and

WHEREAS, information about reconstructive surgical options has become necessary early on to make informed decisions regarding surgical treatment; now, therefore, be it

RESOLVED, that the Kentucky Medical Association recommend the amendment of KRS 311.935 to mandate, additionally, that each woman diagnosed with breast cancer in the Commonwealth of Kentucky must receive comprehensive information about psychosocial counseling resources and reconstructive surgery options; and be it further

RESOLVED, that such amendment, by addition and deletion, shall then read:

....Any physician licensed under the laws of the Commonwealth who treats a patient for any form of breast cancer shall provide the patient with a standardized written summary, as provided under this Section, informing the patient of medically efficacious and viable alternative methods of treatment for breast cancer which may include surgical, radiological, or chemotherapeutic, psychological counseling, or reconstructive surgical treatment or combinations thereof.

Recommendations, Reference Committee B:

Reference Committee B reviewed Resolution 119, Mandated Information for Women Diagnosed with Breast Cancer, and recommends that it be amended by deletion of the existing Resolveds and substitution of the following Resolved:

RESOLVED, that KMA recommends that the written summary of information on alternatives in the treatment of breast cancer as mandated by KRS 311.935 contain information about psychosocial counseling resources and reconstructive surgery options.

Reference Committee B recommends Resolution 119 be adopted as amended.

RESOLUTION 96-125

Pap Smear as a "Clinical" Laboratory Test Fayette County Medical Society

WHEREAS, pathology services are composed of two major areas, anatomic and clinical pathology, with the two major components of anatomic pathology being the histopathology and cytopathology disciplines; and

WHEREAS, gyn-cytopathology services are universally performed under the supervision and the direction of a qualified anatomic pathologist; and

WHEREAS, gyn-cytopathology and the subsequent follow-up cervical tissue examinations are integrated tests for the purpose of management of cervical cancer and precancerous lesions and such continuity enhances the quality of care; and

WHEREAS, the Bethesda Workgroup, sponsored by the National Institutes of Health, has determined the cervical smear and its interpretation to represent a medical consultation between the clinician and pathologist; and

WHEREAS, gyn-cytopathology has been erroneously classified as "clinical" laboratory services by HCFA under Medicare/Medicaid programs; and WHEREAS, misclassification has resulted in this medical consultation being included in bidding for largely high-volume, automated serologic hematologic, chemistry, and microbiologic testing menus; and

WHEREAS, these large contracts are awarded predominantly on consideration of aggregate cost with little regard to specific characteristics of the cytopathology process and its effect on patient care; and

WHEREAS, the traditional Pap test is still the single most important and cost effective method for the prevention of cervical cancer; now, therefore, be it

RESOLVED, that the KMA ask AMA to seek from HCFA and managed care groups reclassification of Pap smear screening as a medical consultation; and be it further

RESOLVED, that KMA ask AMA to seek removal of Pap smear screening from categorization as a clinical laboratory test and seek exclusion of Pap smear screening from clinical lab bids proposed by managed care groups.

Recommendations, Reference Committee B:

Reference Committee B reviewed Resolution 125, Pap Smear as a "Clinical" Laboratory Test, and recommends adoption of Resolution 125.

Mr Speaker, Reference Committee B recommends adoption of this report as a whole.

Mr Speaker, I would like to thank the other members of the Committee: Gordon W. Air, MD, Crestview Hills; Kathleen J. Bos, MD, Lexington; Cecil D. Martin, MD, Carrollton; Michael Todd Newman, MD, Lexington; and Brenda I. Townes, MD, Louisville. I also want to personally thank Ms Valarie Knat for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE B
William D. Pratt, MD, London, Chair
Gordon W. Air, MD, Crestview Hills
Kathleen J. Bos, MD, Lexington
Cecil D. Martin, MD, Carrollton
Michael Todd Newman, Lexington
(MSS)
Brenda I. Townes, MD, Louisville

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE C

Daniel E. Kenady, MD, Lexington, Chair

- 22. Report of the Maternal Mortality Study Committee
- 23. Report of the Committee on National Legislative Activities
- 24. Report of the Committee on State Legislative Activities
- 25. Report of the Committee on Professional Liability Insurance
- 26. Report of the Committee on Care for the Elderly
- 27. Report of the Public Education Committee
- Report of the Ad Hoc Committee on Controlled Substances
- Resolution 104 — Tribute to Physician Elected Officials (Board of Trustees)
- Resolution 108 — Medicaid Program (Fayette County Medical Society)
- Resolution 110 — Physician/ARNP Collaborative Agreements (Board of Trustees)
- Resolution 114 — Patient Protection (Jefferson County Medical Society)
- Resolution 115 — Physician Provider Tax (northern Kentucky Medical Society)
- Resolution 120 — Pharmaceutical Manufacturers Link to Managed Care (Fayette County Medical Society)

ITEMS FOR CONSENT

Reference Committee C reviewed the following items and recommends they be filed, by consent of the House, without discussion:

- 23. Report of the Committee on National Legislative Activities — filed
- 25. Report of the Committee on Professional Liability Insurance — filed
- 26. Report of the Committee on Care for the Elderly — filed
- 27. Report of the Public Education Committee — filed
- Report of the Ad Hoc Committee on Controlled Substances — filed

Mr Speaker, Reference Committee C would like to express its appreciation to the authors of these reports which have been filed and the efforts spent in gathering this information for the House of Delegates. Reference Committee C recommends the adoption of the Consent Calendar as a whole.

Report of the Committee on National Legislative Activities

The Committee on National Legislative Activities has observed one of the more unique periods of American political life this year, which began with Republican domination of both houses of Congress and a GOP commitment to significant changes. Few of these proposed changes in themselves were controversial, but they constituted a political gauntlet thrown as a challenge to Democrats and to some economical trends.

The obvious major focus of legislative activities this year surrounded the balanced budget issue. Obviously a major component of the balanced budget was health care reform through Medicare/Medicaid and budgetary effects on welfare. In November, Congress passed a budget that would save \$900 billion over seven years. The President vetoed this budget and the government and Congress went through a continuing series of budget extension resolutions. While these issues may have begun as a test of philosophies, the result has become a test of political accomplishment.

During the current session of Congress, all legislation can be directly tied to the upcoming presidential and congressional elections. Initially, the partisanship that flavored Congress worked to the betterment of medicine's goals, but our more seasoned representatives have seen the partisanship and this focus on elections has resulted in legislative gridlock.

Once it was observed that proposed Medicare, Medicaid, and welfare changes would be dormant until after the election, medicine focused its priorities on antitrust issues, reform of the Clinical Laboratory Improvement Act, insurance reform, and tort reform.

HR 2925, sponsored by House Judiciary Committee Chair Henry Hyde, relates to physician service networks for managed care. Under current rules, if physicians join together and fix fees it would be a "per se" violation of antitrust laws. This bill would require the Federal Trade Commission to apply the "rule of reason" to providers-sponsored networks and require them to meet the same rules that nonphysician groups must observe.

Obviously, this is an important bill to physicians and threatening to

insurance companies, which constitute the major opponent. The most recent episode in this situation is that hospitals, nurses, insurers, and HMOs have joined together to oppose the bill, stating that it will give physicians unfair advantage in competition, will encourage price fixing and boycotts, and will limit choice. Ironically, these are exactly the same arguments that medicine has used to substantiate the need for antitrust relief. Although passed by the House Judiciary Committee, this bill now lies dormant, a victim of presidential election politics.

Representative Bill Archer, Chair of the House Ways and Means Committee, sponsored HR 1386 which would reform the Clinical Laboratory Improvement Act. The intent of CLIA was to legislate quality, but the result has been to burden physicians with onerous regulations, excessive inspections, and unnecessary documentation. There is no proof that CLIA has improved quality or had any measureable impact on high-tech, tertiary, or reference laboratories who were the genesis of the original legislation. As with the Hyde bill, Kentucky has several congressmen who have cosponsored this bill.

A relatively simple health insurance reform bill was sponsored by Senator Nancy Kassebaum, Chair of the Labor and Human Resources Committee, and cosponsored by Senator Ted Kennedy. S 1028 was intended as reaction to congressional partisanship and an effort to "pass something." The House version of this bill passed in March with bipartisan support, but included amendments disassociated with health insurance reform which included a \$250,000 cap on medical liability awards, a medical savings account provision, and fraud and abuse provisions.

There is some hope that each of these issues may experience legislative success. Congress has already begun quietly working on the next fiscal year's budget and has established some ground rules to streamline the legislative process. As an example, the House has agreed to consider Medicare, Medicaid, and welfare as three separate subjects for budgetary purposes, and it is hoped that medicine's legislative priorities can be productively included.

I would like to thank each of the Key Contacts for his invaluable help in "keeping the information coming" to their congressmen and to all members who have expressed their views to our legislators. A special word of thanks is due to the KMA Alliance which was invaluable in promoting legislative alerts that resulted in increased contacts from physicians.

**Donald C. Barton, MD
Chair**

Report of the Committee on Professional Liability Insurance

The Committee on Professional Liability Insurance is composed of the KMA Executive Committee and the Chair of the KMA Committee on State Legislative Activities. The Committee met formally on one occasion and discussed continuing concerns with the status of AMA's and KMA's legislative efforts.

We concentrated most of our efforts on the national levels as Congress heatedly debated the tort reform measures touted by the AMA. In the first session of the 104th Congress, the House of Representatives capped noneconomic damages in medical liability cases via an amendment to the Product Liability Bill. The Senate rejected AMA's amendment but several heroic efforts were made by House leadership to place the tort reform provision back into the Conference Compromise. As most of you are aware, President Clinton ended up vetoing the bill.

During the second session, we have attempted to include tort reform in the Kassebaum-Kennedy "Health Insurance Reform" legislation (S. 1028). On the House side, HR 3103, the companion bill to Senate Bill 1028, has a liability cap provision which has been adopted by the House. The bill now awaits the Conference Committee report.

Efforts have been made and will continue to be made in both sessions to attach the liability cap to the following legislation:

- Budget Reconciliation Bill
- Anti-trust Bill
- Clinical Laboratory Improvement Act Bill
- Free-standing Legislation
- Reattach to the Product Liability Bill

As you are aware, the KMA Committee on Professional Liability Insur-



ance contributed \$5,000 to assist AMA in the public relations arena to combat trial lawyers' misinformation campaign. The committee has been deeply impressed by AMA leadership and their lobbyists' dogged determination in bringing the growing liability crisis to Congress' and the nation's attention. The committee is extremely appreciative of their efforts.

On the state level, KMA continues to support a constitutional amendment to permit the Kentucky General Assembly to place a limitation on noneconomic awards. Section 54 of the Kentucky Constitution states, "The General Assembly shall have no power to limit the amount to be recovered for injuries resulting in death or for injuries to person or property." Typically, we introduce the proposed constitutional amendment early in the Session for consideration. However, we were concentrating on repealing the provider tax, amending House Bill 250, and restoring Medicaid reimbursement. In addition, a highly charged partisan battle in the Senate dramatically altered any attempt to get such an amendment passed. Fourteen (14) of the thirty-eight (38) Senators are lawyers which further complicated our efforts. Recognizing that our efforts would be futile in 1996, and knowing that our legislative agenda was full, we elected not to pursue the amendment in 1996.

We continued our battles with the trial bar over several legislative issues. Senate Bill 139 would have permitted a child to collect civil damages for loss of consortium with a parent. While the sponsors had not recognized the impact this legislation would have, if adopted, on medical liability, they did agree to withdraw the legislation. In addition, we were successful in removing the development and enforcement provision of HB 250 which called for practice parameters. As you recall, HB 250 called for the development and use of practice parameters with the provision that if physicians rendered care in accordance with the practice parameters, they would be presumed to have met the "standards of care." Several concerns with the practice parameters provision led us to the conclusion that the section should be repealed. First, if the physician followed the practice parameter and was later sued, would the courts have upheld the law? Secondly, if the physician failed to follow the practice parameter, could he or she be sued for malpractice? Finally, we were not happy with the committee appointed by the state and the inclusion of many nonphysicians within this structure. The Legislature accepted our argument which was enhanced by the fact that the full cost of the state establishing and maintaining practice parameters in a dramatically changing medical care climate would not only be impossible but economically unfeasible.

On behalf of the KMA Committee on Professional Liability Insurance, we deeply appreciate the membership's support of this special effort to address tort reform.

Through your patience and financial support, we are able to enhance our legislative effort and present a highly visible lobbying effort on behalf of all of our patients and the profession.

Wally O. Montgomery, MD
Chair

Report of the Committee on Care of the Elderly

Each year the Committee on Care of the Elderly undertakes a planning process where it identifies subject areas of interest to both physicians and elderly patient groups. The committee then consults with elderly advocacy groups with which it has formed relationships over the years and, finally, develops a seminar to provide information and allow interchange among the medical, patient, and other advocacy communities. This year planning was focused on changes to the Medicare and Medicaid programs and the positive and negative impacts that these changes would have on the elderly population from a care standpoint.

Everyone who observed the national legislative and political process watched the Medicare and Medicaid programs become political footballs in congressional partisan struggles and, ultimately, focal issues of presidential politics. These programs became the key issues of budget arguments and, therefore, were at the core of partisan philosophy.

In these debates, the proposed changes to Medicaid and Medicare were legion. The overriding direction of all proposals was cost cutting and a reduction of growth in spending with an emphasis on managed care. A major subset of cost cutting was reduction in payments to providers, which

would obviously have a direct impact on the elderly. At this point in the committee's planning process changes could be anticipated, but impossible to predict.

Because Medicare is the single largest payment source for medical care in the country and the single largest care program for the elderly, its modification will obviously be crucial to their present and future. No clear resolution of changes is probable until after the presidential election and the beginning of the new Congress. As a core budget issue, the debate will likely begin anew, and we look anxiously to the outcome of those talks. We will continue to monitor these developments and continue our planning to structure educational opportunities in the coming year.

Legislative focus at the state level on issues affecting care of the elderly was more productive this year. Most changes occurred in the vehicle of Senate Bill 343, which was a revision to the old House Bill 250 of 1994, that effected significant reforms. The first and obvious change was to remove the noninstitutionalized aged population on Medicaid from the KenPAC program. Elderly Medicaid patients will no longer fall under the restrictions of KenPAC and should, hopefully, have more accessibility and availability to medical care as a result. Likewise, KenPAC was retained as the method of managed care under Medicaid for other recipients.

Other reforms which may influence the care delivery to the elderly to a lesser degree are guaranteed renewability and portability of insurance, and the requirement that HMOs now be subject to Certificate of Need.

The state is now engaged in trying to establish regional managed care programs for Medicaid which may have a significant, but as yet unknown, effect on elderly care.

In the coming months, the Committee on Care of the Elderly will become involved in some specific nursing home issues. The Board of Trustees has committed the assistance of the Association to the Cabinet for Human Resources regarding utilization of various ancillary services by nursing home patients and the role of physicians in ordering and monitoring those services. The committee has been charged by the Board of Trustees with representing KMA on this matter, and we anticipate the development of some interesting information.

As Chair, I would like to thank all of the committee members for their help and thank the Board of Trustees for its support.

S. Philip Greiver, MD
Chair

Report of the Public Education Committee

The KMA Public Education Committee continues its efforts to inform the public on health and medical matters and to increase the rapport and trust between patients and physicians. The "flagship" project of the committee is the continuing development, printing, and distribution of *MediScope*, the committee's four-page patient education publication. The *MediScope* publication and distribution now has a circulation of 6,100. This includes approximately 4,700 active KMA members who receive 10 copies of each quarterly issue. Added to the mailing list last year were 1,400 public entities (ie, libraries, school superintendents, county judges and county clerks, legislators, hospitals), and Health Departments were recently added to the list of complimentary recipients of *MediScope*. At this point, 14 KMA members are on the mailing list to receive an additional 100 copies of each issue at a cost of \$15 per hundred, plus postage. The committee continues to search for ways to increase the circulation of *MediScope* which has been received favorably by both legislators and members of the press.

The committee developed and implemented a very comprehensive plan to educate patients on issues prior to the 1996 Kentucky General Assembly:

1. **MediScope** — A special issue of *MediScope* devoted entirely to legislative medical issues was published in January 1996. The committee approved sending 100 copies to all physicians' offices.

Facts and Fables — In 1995 the committee developed an informative booklet entitled *Facts and Fables* which addressed distorted comments, reports, and statistics emanating from the Cabinet for Human Resources relating to physicians, KMA, and Medicaid patients. This project was an obvious success because rhetoric from Frankfort subsided. The format worked very well and will be filed until needed again.

2. **Voting Records** — The committee published voting records of legislators and how they voted on HB 250 in the 1994 Session.
3. **Magazine Ads** — The January-April 1996 issues of *Kentucky Living* magazine included two one-quarter page ads developed by the committee. The theme of the ads was "health care myths." We addressed the liability crisis, health costs, and the growing intrusion of managed care into the physician/patient relationship.
4. **Legislative Videotape** — This videotape was premiered at the 1995 KMA Annual Meeting and then used at all 1996 Pre-Legislative Conferences. Some members also used the tape in local meetings.
5. **Pre-Legislative Conferences** — Approximately 1,200 physicians/spouses attended the 15 regional conferences which included use of the above-mentioned videotape and handouts. The videotape was previewed by the 1995 House of Delegates meeting and was the focal point of the Pre-Legislative Conferences. The video was also mailed to all 15 Districts with a request by KMA President Danny M. Clark, MD, that it be shown at hospital medical staff meetings. Information on the provider tax and Medicaid cuts which was printed on a "credit card-size" card was distributed to all KMA and KMAA members.
6. **Special Session of the KMA House of Delegates** — The committee funded the taping and distribution to the media on the Special Session of the House of Delegates. The tape was beamed by satellite to TV and radio stations. Several TV stations in the major media centers used the tape, while approximately 170 radio stations broadcast portions of the audiotape. In addition, the committee mailed press releases to every daily and weekly newspaper in Kentucky.

KMA had a very successful legislative session in 1996 as it addressed the crucial issues embodied in HB 250 which had been adopted by the 1994 General Assembly as a result of Governor Brereton Jones' initiatives. We believe the Public Education Committee played a crucial role in informing and educating the public and our patients on issues that affect them, their families, and their pocketbooks.

A new committee logo, as proposed by Consultant Glen Bastin, was approved. This logo will be used to identify the KMA Public Education Committee in various different ways, ie, publications.

Mrs. Marla Vieillard, KMAA President, presented a proposal by the Alliance to donate 10,000 coloring books to each public elementary school in the state for distribution to grades K-3. The coloring books, entitled "I Can Choose," contain messages on self-esteem, pride, confidence, etc. Her proposal called for purchasing these books from the AMA Alliance and having the KMA Alliance logo stamped on the back of each book.

A grant of up to \$4,000 was approved for the KMA Alliance to purchase and distribute 10,000 "I Can Choose" coloring books to Kentucky school children in grades K-3. An additional cost was paid for customizing the back of the books to include the KMAA logo and the KMA Public Education Committee logo.

Mrs. Vieillard also presented a textbook cover to the committee which addressed the AIDS issue. It was the Alliance's desire to distribute these book covers to 9th and 10th grade students and have the Public Education Committee listed as a contributor on the back of the book cover. The amount of \$400 was contributed to the printing of AIDS prevention book covers to be distributed to Kentucky's 9th and 10th grade students. A list of sponsors of the project to be printed on the back will include the Kentucky Medical Association.

Staff reported that following an article in *MediScope* regarding the availability of the "I Can Choose" book, over 100 telephone calls were received at the KMA office requesting additional copies of the book. Approximately 3,500 books were requested in addition to the 10,000 already approved from the Public Education Committee budget for distribution in schools. The committee will send up to 10 additional copies to the individuals and information on how more copies can be obtained from the AMA Alliance.

The committee was polled in January 1996 regarding the possibility of presenting a videotape to the 1996 House of Delegates explaining the public education activities of this committee, the Legislative Committee, KEMPAC, and Board activities. After discussion, it was agreed that the video should be produced and used in conjunction with the written report provided to the House of Delegates.

This committee is actively seeking new, innovative, and effective projects which enhance the physician/patient and public/profession image. Several projects were submitted for consideration:

1. **Internet** — The Committee is in the process of considering a page on the Internet along with KMA's consideration of opening an Association location. If the concept is developed, the committee will work with KMA staff on details. Our consultant distributed a proposed budget for start-up costs for the first year which totaled \$2,800 for 10 pages. This included a one-time cost for page design and setup of \$500. He suggested consideration of an open-end section that the committee could adjust monthly; ie, use of the "President's Page" from the *KMA Journal* or legislative bills of interest during the session. Other suggestions included a "Disease of the Month" page. If approved by the Executive Committee, the Public Education Committee will proceed with developing a home page on the Internet for patient education. If KMA itself develops a page, the two may be linked.
2. **KMA Booklets for Children** — Due to the public's response to the "I Can Choose" books, Mr Bastin proposed the possibility of this committee developing and printing its own activity book for children which would promote the profession and the Association. KMA members could offer suggestions for activities to be printed in the book and the Alliance could be asked to distribute the books. Approval was granted to proceed with obtaining costs and to work with the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan to develop a book.
3. **Note Pads** — Since most prescription pads promote drug companies, Mr Bastin suggested that this committee consider printing note pads which promote the profession. It was suggested that the possibility of printing these pads as a "post-it" pad be considered. If price permits, the committee will consider distributing these at the Annual Meeting.
4. **Other** — The committee is also considering having voter registration forms inserted in telephone books, planning its public education strategies for the 1998 legislative session, and considering the use of a toll-free telephone number to access a recorded message concerning medical bills of interest being considered during the session and suggestions on how callers can influence their legislators.

On behalf of the committee, I want to express appreciation to the KMA House of Delegates and the Board of Trustees for their continued support for the committee and its projects. We are relatively new in this business — just completing our third year. We are extremely proud of our ongoing projects and hopefully in the near future we can add new ones to our list. Your Chair reports to all KMA Board meetings and staff regularly updates the KMA Executive and Quick Action Committees on our strategies and plans.

All of us recognize the public's pent-up demand for more health and medical information. Your Public Education Committee continues to aggressively act — and react — to our patients' needs and tailors its programs to meet the public's search for health care topics. The committee again expresses its special thanks to Mr Glen Bastin, our PR Consultant, who has become an integral ingredient to the committee's work. While Mr Bastin is in the PR business, he has become a tremendous personal advocate for physicians and patients.

On behalf of the committee, we thank the membership and House of Delegates for your financial and moral support. We do seek your advice and counsel and if you have suggestions or ideas on how we can become more effective, don't hesitate to contact a member or staff.

Preston P. Nunnolley, MD
Chair

Report of the Ad Hoc Committee to Study Guidelines for Prescribing Controlled Substances

This committee was appointed by the KMA Board of Trustees to study guidelines for prescribing controlled substances that had been received by the Kentucky Board of Medical Licensure (KBML). The guidelines had been primarily drafted by L. Douglas Kennedy, MD, Lexington, who is an anesthesiologist and certified specialist in pain management.

The KBML has long been concerned about the number of physicians, although a minority, about whom complaints are filed, or about a few that are not achieving a minimum standard of care in their practices. Many of the complaints and investigations generated center on the inappropriate prescribing of controlled substances. In light of that, it asked the KMA Board of Trustees to study and offer recommendations to the KBML for



implementation of the submitted prescribing guidelines. It was the understanding of the committee that the KBML would like to obtain the support of KMA in publishing these or similar guidelines as just that, guidelines, not formalized administrative regulations or parameters. They would expect the guidelines to assist Kentucky physicians in making decisions about management of patients with chronic pain and/or emotional disorders, and to make informed and appropriate uses of anorectic drugs.

The committee met formally on four occasions to study and discuss the submitted guidelines. After long and thoughtful review, the committee proposed that the guidelines be presented in two parts, a summary for quick reference and a more detailed explanation of the guidelines. This proposal was submitted to the KMA Board of Trustees at its meeting April 17-18, 1996. The Board approved the committee's report and forwarded same to the KBML for consideration and implementation.

As Chair of this committee, I would like to thank my fellow committee members for their dedication and focus. These members are David W. Douglas, MD, London; Vaughn Payne, MD, Louisville; Marilyn Sanders, MD, Owensboro; and James R. Schrand, MD, Florence. I would also like to thank the KMA Board of Trustees for allowing me and the committee the opportunity to be of service to Kentucky physicians.

E. C. Seeley, MD
Chair

END OF CONSENT CALENDAR ITEMS

Report of the Maternal Mortality Study Committee

The Maternal Mortality Study Committee of the Kentucky Medical Association met once during the organization year — September 29, 1995. Only three cases were available for study. Considerable detailed discussion took place among the committee. After extensive review, the following classifications were made.

MATERNAL MORTALITY STUDY TABLE

| | |
|--------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Direct Obstetric | Patient is a 34 Y/O, married, white female, G11, P8. She had three previous cesareans. During this pregnancy at seven months she had sudden onset of abdominal pain and was brought into the emergency room in terminal state. An autopsy showed: a. Myometrial dehiscence b. Partial placenta previa c. Massive intraperitoneal hemorrhage d. In utero fetal death due to maternal intra-uterine death e. Status post prior cesarean section Death in this case is due to internal hemorrhage as the result of ruptured gravid uterus. Preventable factor — question of sterilization at third cesarean since uterus had ruptured and had been repaired at last cesarean. |
| Indirect Obstetric | Questionable preventable. Patient at 30 weeks gestation was medicated with terbutaline. Within 24 hours she had severe headaches and was taken to a local hospital and died of occlusion of the middle cerebral artery. An autopsy confirmed this. |
| Direct Obstetric | Previous factors. Late prenatal care. Pregnancy complicated by hypertensive disease. Main cause of death was cardiac tamponade. It was emphasized that a cardiac tamponade is a difficult diagnosis to make although an attempt was made to relieve cardiac tamponade. Obesity of 240 lbs. was felt to be a contributing factor. |

We are indebted to the diligent efforts of Dr John Petry for his significant contributions in finding and preparing cases for the study committee.

I wish to remain a member of the Maternal Mortality Study Committee. However, Dr Stan Gall will assume the chairmanship this year. I have been a member of the committee since coming to Kentucky in 1963 and Chair since 1970. I have had great fulfillment in being a part of this work with Dr Petry and all the committee members.

John W. Greene, MD
Committee Chair

Recommendations, Reference Committee C:

The reference committee has reviewed the information provided in the Report of the Maternal Mortality Study Committee. It was brought to the committee's attention that a death reported two to three years ago has never been reported as a maternal related death. We recommend that the Maternal Mortality Study Committee pursue changing the method of reporting maternal deaths to allow more accurate collection of data. This will require a recommendation for legislative action to come out of this committee at the next meeting.

The committee recommends the Report of the Maternal Mortality Study Committee be filed.

Report of the Committee on State Legislative Activities

The following 1996 legislative plan of action was adopted by the KMA Board of Trustees based on KMA House of Delegates' policy and positions established by the Board of Trustees.

I. Primary Goals

1. Repeal the Physician Component of the Provider Tax
2. Tort Reform
Amend Section 54 of the Kentucky Constitution to permit the KGA to cap noneconomic damages.

The KMA House of Delegates established the provider tax as the major priority for 1996. In addition, the House has reaffirmed tort reform as a major and primary objective of KMA's legislative program.

II. Secondary Goals

1. Repeal the Discount Option Program
2. Free Medical Records
Permit providers to charge reasonable fees to provide copies of medical records.
3. Practice Parameters
Repeal or correct discrepancies or deficiencies in HB 250 relating to practice parameters and clarify their purpose, future use, and implementation.
4. Support retention of the Any Willing Provider provision.
5. Continue to work with the Administration and the Kentucky General Assembly seeking fair and equitable reimbursement for services rendered to Medicaid patients.

The 1995 KMA House of Delegates adopted several reports and resolutions that were referred to the Committee on State Legislative Activities for either action or information. The noted resolutions or reports, along with Kentucky General Assembly and KMA action, are as follows:

1. Substitute Resolution P — Release of Patient Information to the Health Policy Board

Resolved, that KMA oppose, via reasonable legislative, administrative, and legal means, all onerous portions of House Bill 250, including those portions pertaining to reporting of data to the Health Policy Board by physicians.

Resolved, that KMA continue its unrelenting efforts to focus its legislative efforts to effect health care reform that promotes high quality patient care through effective use of physician resources.

KMA Action: In large measure, we succeeded on all counts. While the insurance reforms of HB 250 were retained, the following provisions of the law were either substantially modified or repealed in their entirety:

- Health Care Policy Board — repealed.
- Powers and Duties of the Board — repealed.
- Discount Option Program — repealed.

Fee Posting — reports of charges of fees for services to be submitted to the Board — repealed.

State-established Practice Parameters — repealed.

Association Exemption — exclusion of association health plans from the Alliance.

Provider-Sponsored Networks — solvency and other important provisions are clarified.

Self-Referral Restrictions — modified to make Kentucky's law no more stringent than federal requirements.

Insurer Misrepresentation — an insurer or managed care network cannot imply or represent that a provider is part of a network unless authorized to do so by the provider.

Any Willing Provider — remains in the law.

Certificate of Need — financial threshold triggering the requirement for a CON for major medical equipment is equalized by physicians and hospitals at \$1,500,000.

Data Collection — KMA included total repeal of data collection of health cost and quality in SB 343, HB 908, SB 91, and numerous other bills and amendments, both in the Senate and the House. We even prevailed on the House floor when several House members sought to reinsert data collection. We prevailed on a vote of 57-36. In the end, however, the Free Conference Committee report retained the data collection element, even though commitment was made that health data collection and health cost/quality would not come from providers, particularly physicians. The Administration had indicated, and informed the Board of Trustees, that it will concentrate its data collection efforts on insurance companies.

Medical Records — KMA made several efforts to repeal the free medical records provision. First, we inserted it in SB 343. After the Senate Committee Substitute placed the provision back in SB 343, we made an attempt on the Senate floor, through SFA 43. We failed on the Senate floor vote because 14 of 38 Senators are attorneys.

We then went to the House and successfully amended HB 512 in the House Judiciary Committee which also has numerous attorneys. We were able to bring HB 512 out of the Judiciary Committee with an amendment that eliminated the free medical records provision. That bill, however, never made it out of House Rules. We then included the provision in HB 908. Unfortunately a Free Conference Committee decided to go with SB 343. After quite a tussle in the Free Conference Committee with trial lawyers, we were unable to overcome their objections.

2. Resolution T — Physician Assistants

Resolved, that the Kentucky Medical Association endorses legislation that credentials Physician Assistants in Kentucky as licensed health care providers who are required to practice with the supervision of licensed physicians; and

Resolved, that the Kentucky Medical Association endorses legislation, regulations, agency and institutional policies that authorize that health care services provided by Physician Assistants be reimbursed to the practice in which the Physician Assistant functions.

KMA Action: HB 402 would have granted non-narcotic prescriptive privileges to PAs. However, the bill that cleared the House rather easily was killed in the Senate.

Following the session we met with Cabinet officials regarding reimbursement for PA services, but received little assurance that our request would be seriously considered. The Cabinet officials pointed out that with the advent of block grants and the formation of regional health provider managed care entities for Medicaid patients, they were very reluctant to reimburse additional providers at this time.

3. Resolution R — Optometrists as Primary Care Providers

Resolved, that the Kentucky Medical Association opposes any legislation allowing optometrists to provide, act, or serve as primary care providers in performance of the practice of medicine, surgery, or laser surgery in the Commonwealth of Kentucky.

KMA Action: HB 390 proposed granting managed care patients direct access to both optometrists and ophthalmologists. While HB 390 was adopted in the House and cleared the Senate Licensing and Occupations Committee, the bill died in the Senate Appropriations & Revenue Committee. No attempt was made by optometrists to introduce enabling "surgical" legislation.

4. Report of the Committee on State Legislative Activities — urge the Kentucky General Assembly to appoint a Task Force to study the

issue of the limited supply of extended care beds in Kentucky.

KMA Action: SCR 110 was introduced at KMA's request; however, the Resolution never received a hearing.

5. Resolution E — Youth Access to Tobacco Products

Support appropriate legislation to decrease youth access to tobacco and increase fines for illegal tobacco sales.

KMA Action: In accordance with Resolution E, adopted by the 1995 House of Delegates, KMA supported SB 137. Resolution E directed KMA to support efforts that increase fines for tobacco sales to minors. SB 137 increases fines currently on sellers of \$10-\$25 to \$100-\$500. Minors who purchase tobacco can be fined \$50 and forced to serve 20 hours of community service for the first offense, and fined \$200 and 40 hours of community service for subsequent violations. Current fines of \$100-\$250 for giving free tobacco products (samples) to under-age children are increased to \$1,000-\$2,500. Vending machine violations currently carry fines of \$10-\$25 that will be increased to \$100-\$500. Retail establishments that fail to notify all employees of the requirements of the law can be fined for \$100-\$500 (up from \$10-\$25).

The 1994 Act providing no funding for enforcement. According to the newly elected Agriculture Commissioner, Billy Ray Smith, in the past the Agriculture Department had two part-time seasonal employees enforcing the law. The Governor proposed that 1/10th of one cent of the tax on tobacco, which will generate from \$500,000 to \$600,000, be used to beef up enforcement efforts. The enforcement of the law has been placed in the hands of Alcohol and Beverage Control agents and an Executive Order from the Governor required that the state police get involved in enforcement activities. The provision that prohibited entrapment has been removed.

The KMA continued to recommend a provision to permit local communities to pass more stringent laws if they feel appropriate. We will also continue to support modifications to the law to fine owners who knowingly encourage or ignore the sale of tobacco to minors by employees.

6. Resolution I — Reaffirming Provider Tax Opposition

KMA Action: Provider Tax on physicians was repealed through a three-year, four increment phase-out commencing August 1, 1996.

Provider Tax

Effective August 1, 1996 — 1.5%

August 1, 1997 — 1.0%

August 1, 1998 — .5%

August 1, 1999 — 0

The repeal of the provider tax was the most difficult issue facing KMA in the 1996 Session. We were confident until January 15 when HB 246, legislation to remove association health plans from the Alliance, was brought to a screeching halt on the House floor when two Republicans attached amendments to totally repeal HB 250. A bipartisan committee was formed which included physicians Jim Crase and Ernie Fletcher. This bipartisan committee worked with Lt Governor Steve Henry, MD, for six weeks. At the end of those six weeks, it became apparent there would be no bipartisan agreement. The Lt Governor would not give up, though; he continued to work with Republicans, but in the end both Republicans and Democrats refused to support SB 343, introduced by Senate Floor Leader, David Karem.

During this lull, Representative Ernie Fletcher, MD, drafted HB 908 that became the preferable legislative proposal in the House. During the six-week hiatus, the Administration garnered enough votes in the House to ensure a phase-out of the provider tax on physicians. From the beginning, Governor Patton made it very clear that he would oppose a total repeal of the physician component of the provider tax. The Governor had made four campaign commitments for tax reductions, and in all cases he was recommending a phase-out rather than total repeal.

At this point, KMA leadership had several options. HB 397 had been introduced by Majority Floor Leader Greg Stumbo for a phase-out of the provider tax. That bill had been referred to the Appropriations & Revenue Committee for consideration. HB 397 came out of the Appropriations & Revenue Committee on a vote of 27-1 for phase out. KMA could have attempted to place an amendment on this bill and force a vote for immediate repeal. But we had a problem — if the votes were there for repeal would Majority Floor Leader Greg Stumbo call the bill? We thought that highly doubtful.

The rules by which the Legislature operates dictate that bills can only be voted on when called. There was never an option, as some seem to think, that KMA could have called for a vote on the provider tax at any



time. That's not the way the Legislature operates. The provider tax was handled very carefully. The Majority Floor Leader, Greg Stumbo, who determines what and when legislation will be considered, was the sponsor of the physician provider tax bill. Several legislators introduced similar bills, but no one challenged the Majority Floor Leader.

The tax phase-out bill sailed out of the House on a vote of 87-4, and went to the Senate where it was referred to the Senate Appropriations & Revenue Committee. On March 19, the Senate A & R Committee reported the bill favorably, and on March 22, the bill passed the Senate 35-3. On March 28, the bill was signed by the Governor. We briefly considered going to the Senate floor for total repeal — there is a possibility we could have prevailed. However, there were some real concerns and risks. Even if we had pulled it off in the Senate, a face-off would have taken place between the Governor and House leadership against the Senate over total repeal.

I am confident the Governor and House leadership would have never yielded. In that case, we would have ended up with the 2% tax for another two years, another poor relationship with a Governor, but an elated Revenue Cabinet. As a result of all these discussions with the Legislative Quick Action Committee and members of the legislative body, we made the decision to recommend working with the Governor. We had already begun discussions of Medicaid reimbursement issues and settlement of the federal lawsuit, along with various HB 250 provisions. The entire issue was considered by a Special Session of the House of Delegates which supported our recommendations.

7. Resolution J — Provision for Decision to Withhold Futile Medical Intervention by State-Appointed Guardianship Services

Resolved, that the KMA work with the Legislature to develop a more workable and timely process to allow decisions to be made regarding advanced directives and termination of inappropriate medical intervention in patients, who are wards of the state, on a case-by-case basis.

KMA Action: We made several efforts to address Resolution J during the 1996 Session. Due to the bitter, adversarial confrontations over abortion, along with the battle over health care reform, legislators were reluctant to deal with these issues in 1996.

8. Resolution D — Insurance Coverage for Obstetrical Care

Directed KMA to support legislation that would prevent third-party payers from interfering, by refusing to pay for care, with physicians' clinical judgment regarding patient care, including timing of discharge.

KMA Action: HB 186 addressed maternity benefits and so-called "drive-through" delivery. The General Assembly adopted HB 186 which requires a 48-hour hospital stay for a normal delivery and 92 hours for cesarean delivery. There is a provision that permits a managed care plan to provide home nursing and reduce the stay if physician and patient agree.

9. Resolution H — Patient Protection and Preservation of Choice

Support the priority of patient welfare in all managed care programs and the patient's rights to be advised of specific plan requirements and exclusions.

KMA Action: In accordance with Resolution H, adopted by the 1995 House of Delegates, KMA drafted a Patient Protection and Preservation of Choice Act for consideration during the 1996 General Assembly. Basically, the legislation, SB 365, supported the right of patients in any managed care plan to be fully advised about the policies/rules of the plan, provided for physician fairness in managed care plans, and provided for a point-of-service feature in all managed care plans.

KMA continues to advocate enactment of state laws and regulations that provide for patient protection and physician fairness in managed care organizations.

KMA Action: In addition to SB 310, KMA's Patient Protection Act, two other measures were introduced to deal with patient/physician concerns. SB 49, which was adopted, requires patients and health care providers to be notified of their right to appeal adverse determinations of private review agents to reduce or deny payment of health benefits.

Additionally, Senator James Crase, MD, introduced controversial SB 316, which was bitterly opposed by HMOs and other insurers, as it required that review agents be physicians licensed by the Kentucky Board of Medical Licensure.

KMA advocate enactment of state laws or administrative regulations which provide for a point-of-service feature that is to be required in all managed care plans which have a closed panel and are approved by the Health Policy Board, and to work with the Health Policy Board to require

a point-of-service feature in all non-ERISA managed care plans that have closed panels.

KMA Action: SB 310 specifically addressed all the above issues, particularly the "point-of-service" feature.

10. Resolution S — Medicaid Reimbursement

KMA actively promote a reasonable reimbursement rate for Medicaid providers.

KMA Action: The settlement of the federal Medicaid lawsuit filed by KMA addressed the Medicaid reimbursement issue. While the Report of the Chair, Board of Trustees addresses the issue, the following agreements are included: 1) retroactively reimburse Kentucky physicians \$52 million; 2) increase biennial physician reimbursement by \$52 million; 3) establish a Medicaid advisory committee to address long-term issues of Medicaid; including reimbursement and access.

During the 1996 Session there were 1,633 bills and resolutions introduced, of which KMA followed 201, or 12%. While the preceding information outlines 1994-95 House of Delegates' actions and legislative results, previous House action was also addressed.

Over the years we have seen a rash of nonphysician practitioner legislation. During the 1996 Session, 32 groups introduced or were considered in various legislative proposals. Traditionally, some groups get most of our attention and the 1996 Session was no exception.

Advanced Registered Nurse Practitioners

Over 48 states permit Nurse Practitioners to prescribe to some degree. In many states, there are few restrictions, and several states permit them to prescribe without limitation. States that have previously adopted this type of legislation report little or no problems.

In 1992 the KMA House of Delegates adopted Resolution R. Resolution R called for KMA to support prescriptive privileges for ARNPs, provided several requirements were included. Resolution R required that a collaborative agreement must exist between the physician and ARNP and that prescriptive privilege be limited to nonscheduled drugs. After many meetings with representatives of the Kentucky Nurses Association, HB 358 was introduced and supported by KMA. The bill met House of Delegates' requirements. Three of the four physician legislators strongly supported the measure, along with Lt Governor Henry. The Board of Medical Licensure will be the ultimate determiner of physician/ARNP joint practices and has the authority to address any problem that threatens patient care.

Unfortunately, some misinformation was transmitted during the Session indicating that the bill permitted independent practice. Since 1978, ARNPs in Kentucky have been permitted to practice independently. Other scare tactics were spread, but the bill passed easily despite some delaying tactics by Senator Benny Ray Bailey. Interestingly, while Bailey opposes highly educated, well-trained ARNPs prescribing nonscheduled medication in a collaborative agreement with physicians, at the very same time he was one of the principal legislators responsible for the passage of SB 212 which authorized optometrists to prescribe — of all things — narcotics.

Physician Assistants

In 1993 the KMA House of Delegates adopted Resolution C, which directed the KMA to support prescriptive privileges, under certain conditions, for PAs. HB 402 was introduced and sailed smoothly through the House with KMA's support. Senator Bailey, who consistently supports chiropractic and optometry legislation, scuttled the bill.

Optometrists

Optometrists continue their political onslaught into the practice of medicine despite their lack of training, both in terms of quality and actual patient experience. Optometrists' legislative strategy included several attacks on managed care by 1) seeking direct access to managed care patients, and 2) requiring that any insurer covering a service provided by a physician must also pay for the same service by an optometrist, provided the service falls within the optometrist's scope of practice.

HB 390 permitted optometrists, ophthalmologists, and dermatologists direct access to patients, even though the patient was insured through a gatekeeper type of insurance plan. HB 390 languished in the Senate Rules Committee, and then was referred to the Senate A & R Committee where it died.

Perhaps the most dangerous inroad into medical care was SB 212, which permits optometrists to prescribe Schedule III, IV, and V narcotics for up to 72 hours. The bill was introduced late on a Tuesday evening; it cleared Senator Bailey's Health and Welfare Committee on Thursday morn-

ing at 8:00 AM, and the bill passed the Senate one week later. Despite scientific presentations by two distinguished ophthalmologists who indicated they never prescribed scheduled drugs from an office setting, the General Assembly, bowing to political pressure, nonetheless passed the bill in unbelievable haste. Finally, HB 782, which was adopted, requires HMOs to provide optometry services to patients if the plan includes eye care that falls within the scope of a licensed optometrist.

Chiropractors

Chiropractors also set out in the 1996 Session to eliminate managed care restrictions on their services. In addition, chiropractors continue their efforts to gain access to Medicaid patients. They were successful in gaining passage of HB 782 that provides managed care patients direct access to chiropractors, and ensures that patients can have a "chiropractic gatekeeper." HB 494 "permits" Medicaid to reimburse for services falling within the lawful scope of the practice of chiropractic. As originally introduced, the bill mandated the coverage, but KMA was able to remove the mandate.

Child, elderly, and general domestic abuse have been a major priority of the past two sessions. In 1996, we dealt with over 15 bills relating to abuse; the major legislative proposal resulting from an interim study was HB 309. Among other provisions, HB 309 requires primary care physicians to attend one 3-hour CME course on diagnosing and reporting domestic abuse. Due to the "O.J." stigma, it became obvious that opposition to this provision in HB 309 was futile, and the PR could have been disastrous for KMA, especially when the Governor's wife was the principal advocate. Originally the bill required all physicians to complete the course. The sponsors accepted our primary care amendment and agreed to require that the course be developed in consultation with the Board of Medical Licensure.

We were successful in maintaining the requirement that motorcyclists wear helmets. In addition, we stymied efforts to remove restrictions on children operating all-terrain vehicles. SB 400, sponsored by Senator Crase, which provides needed liability insurance for charitable health care providers, should be extremely helpful to free clinics that use the services of volunteer and retired physicians.

As you can see, KMA had an extremely busy and productive session. We developed a plan immediately following the 1994 Session that coordinated our Legislative Committee efforts with a public relations campaign developed by the KMA Public Education Committee. In addition, KEMPAC became a major player in our efforts by encouraging physicians to become active in campaigns and participate in local and statewide elections.

We want to especially recognize the efforts of our four physician legislators — Jim Crase, Bob DeWeese, Ernie Fletcher, and Nick Kafoglis. All of them serve with honor and are highly respected by their legislative peers and those who deal day-in and day-out with the Legislature. Last, but certainly not least, we want to acknowledge the efforts and tremendous cooperation of Lt Governor Steve Henry, MD. Dr Henry stayed with us through the darkest hours of the 1996 Session, and never wavered in his support of our positions. Without his support, it is questionable that the tax or major provisions of HB 250 would have been repealed, especially in the final days when the withering attack upon medicine's positions took place.

Finally, I want to recognize the efforts of our President, Danny Clark, who led us through this quagmire, always keeping his composure, even in the toughest of situations. Dr Clark was our spokesperson in eight to ten meetings with the Governor. Many thanks to my other Legislative Quick Action Committee members: Bill Mitchell, Bill VonderHaar, Harry Carlross, and Bob Goodin; Jan Crase and the entire KMA Alliance membership; and to all the KMA staff, under the direction of Bob Cox.

After participating in 18 regular biennium sessions and numerous special sessions, Bob Cox will retire. Those of us who have had to endure the stress of the General Assembly have leaned on Bob, especially in the difficult sessions like the 1994 session. We will sincerely miss his strength, experience, and especially his good humor. We wish Bob and Kay the best in their retirement years.

Let me assure you that KMA has the most trusted and best lobbying team in Frankfort. All of our efforts would be in vain without Don Chasteen, David Carby, Bill Doll, and John Cooper. Your Quick Action and State Legislative Committee is extremely proud of this team and we urge you to give them your "thank you."

In closing, let me thank the KMA Board of Trustees, House of Delegates, and all KMA members for your continued support. While we have made some headway in 1996, the battle has only begun. Continue your political

activities and remain alert. Above all, know your state Representatives and state Senators. Surely if you have gleaned nothing else from the past three years, you recognize that the greatest threat to physicians' practices and patient care are members of the Kentucky General Assembly.

On behalf of the entire Legislative Committee, we appreciate the opportunity to serve the profession and look forward to working with each of you in the coming year.

Wally O. Montgomery, MD
Chair

Recommendations, Reference Committee C:

The reference committee has reviewed the information provided in the Report of the Committee on State Legislative Activities and would like to express its appreciation to Doctor Montgomery for his interactions with the legislature and his outstanding reports.

The committee recommends the Report of the Committee on State Legislative Activities be filed.

RESOLUTION 96-104

Tribute to Physician Elected Officials Board of Trustees

WHEREAS, the 1995 KMA House of Delegates adopted an extensive legislative agenda in preparation for the 1996 Kentucky General Assembly; and

WHEREAS, that agenda included repeal of the physician component of the provider tax, repeal or amendment of portions of HB 250, and restoration of Medicaid funding; and

WHEREAS, KMA's legislative agenda was generally adopted; and

WHEREAS, this Association has and will continue to urge physicians to run for public office with particular emphasis upon US Congress, the Kentucky General Assembly, and statewide offices; and

WHEREAS, a key component to KMA's legislative success can be attributed to the effectiveness of our elected physicians; and

WHEREAS, Senator James D. Crase, MD, of Somerset, and Representative Ernest L. Fletcher, MD, of Lexington have chosen not to seek reelection; now, therefore, be it

RESOLVED, that the 1996 KMA House of Delegates offers its commendation and appreciation to these physician public servants, Lt Governor Steve Henry, MD; Senator Nick Kafoglis, MD; Representative Bob DeWeese, MD; Senator James Crase, MD; and Representative Ernie Fletcher, MD who have given so unselfishly to their community, state, and profession, and be it further

RESOLVED, that the House of Delegates, in accordance with the Constitution and Bylaws, honors retiring legislators Senator James M. Crase, MD, and Representative Ernest L. Fletcher, MD, and directs that an appropriate plaque be inscribed and presented to these special physicians; and be it further

RESOLVED, that these commendations become a permanent record of this Association and the 1996 KMA House of Delegates.

Recommendations, Reference Committee C:

The committee considered Resolution 104, Tribute to Physician Elected Officials, introduced by the Board of Trustees, and in order to follow the custom of listing the names of legislators by length of service, recommends rewording of the resolved as follows:

RESOLVED, that the 1996 KMA House of Delegates offers its commendation and appreciation to these physician public servants, Lt Governor Steve Henry, MD; Senator Nick Kafoglis, MD; Senator James Crase, MD; Representative Bob DeWeese, MD; and Representative Ernie Fletcher, MD who have given so unselfishly to their community, state, and profession.

Reference Committee C recommends adoption of Resolution 104 as amended.

RESOLUTION 96-108

Medicaid Program Fayette County Medical Society

WHEREAS, the physicians of Kentucky have long supported the care of uninsured, underinsured, and indigent persons of Kentucky, and



WHEREAS, the Kentucky Medical Association and its physician members have volunteered their time through the Kentucky Physicians Care Program, and

WHEREAS, the physicians have faithfully paid an extra tax to support the Medicaid program; now, therefore, be it

RESOLVED, that the Kentucky Medical Association call for surplus monies in the Kentucky General Fund to be used for support and expansion of the troubled Medicaid program.

Recommendations, Reference Committee C:

The committee considered Resolution 108, Medicaid Program, submitted by the Fayette County Medical Society. Extensive opinion was expressed regarding this resolution. It was the committee's decision that this resolution was vague and might be interpreted as advocating increased monetary support for physicians. It was agreed that the word expansion was not necessarily a good one when used in conjunction with the Medicaid program. The committee recommends the following revision of the resolved:

RESOLVED, that the Kentucky Medical Association call for surplus monies in the Kentucky General Fund to be used for support and expansion of enhanced medical care of uninsured, underinsured and indigent persons of Kentucky through the troubled Medicaid program.

Reference Committee C recommends the adoption of Resolution 108 as amended.

John White, MD, of Fayette County noted that after hearing many concerns about the resolution, Fayette County would favor rejection of the resolution.

A motion was made, seconded, and carried to reject Resolution 108.

RESOLUTION 96-110

Physician/ARNP Collaborative Agreements Board of Trustees

WHEREAS, since 1978, Advance Registered Nurse Practitioners (ARNPs) have been permitted to practice independently; and

WHEREAS, the 1992 KMA House of Delegates, through Resolution R, endorsed legislation to permit ARNPs to prescribe under written protocol with a joint collaborative agreement; and

WHEREAS, the 1996 Kentucky General Assembly adopted HB 358 which permits ARNPs to prescribe nonnarcotic substances provided there is a collaborative agreement with a physician; and

WHEREAS, KMA supports the concept that there should be well-defined limits on the number of prescribing ARNPs physicians supervise and safeguards developed to prohibit independent and unsupervised prescribing practice; now, therefore, be it

RESOLVED, that KMA recommends that the Kentucky Board of Medical Licensure (KBML) consider development of regulations restricting the number of ARNPs with which a physician may have collaborative agreements; and be it further

RESOLVED, that physicians should individualize collaborative agreements based on the need of their patients and their practice; and be it further

RESOLVED, that the KBML assist physicians by developing criteria for collaborative agreements that safeguard patient care including, but not limited to, experience of the ARNP; the ARNP's educational background; appropriate referral patterns; quality assurance; and continuing education; and be it further

RESOLVED, that KMA continue to oppose any effort by ARNPs to prescribe narcotics and oppose independent practice of ARNPs with prescriptive privileges; and be it further

RESOLVED, that KMA continue to oppose any legislation or regulations which undermine the authority of physicians to determine patient care which, in accordance with medical standards, cannot be abrogated.

Recommendations, Reference Committee C:

Reference Committee C next considered Resolution 110, Physician/ARNP Collaborative Agreements, introduced by the Board of Trustees. The committee recommends deletion of the second Resolved since it is duplicated in the third Resolved.

Reference Committee C recommends the adoption of Resolution 110 as amended.

Harry W. Carloss, MD, representing the Board of Trustees, recommended that Resolution 110 be adopted as originally worded.

A motion was made, seconded, and carried to adopt Resolution 110 as originally worded.

RESOLUTION 96-114

Patient Protection Jefferson County Medical Society

WHEREAS, in today's rapidly changing environment of health care delivery, increased economic incentives are imposed from outside the medical profession, and growing numbers of nonphysicians are attempting to influence patient care decisions; and

WHEREAS, such impositions upon the patient-physician relationship may not be in the individual patient's best interest, and may in fact diminish the quality of care available to the patient; and

WHEREAS, the medical profession, with its federation of professional associations, is in the strongest position to launch an assault against any attempted violation of the patient-physician relationship; now, therefore, be it

RESOLVED, that the Kentucky Medical Association appoint a study committee to evaluate the American Medical Association's model patient protection act, and other state-enacted legislation, in order to consider their applicability as possible Kentucky legislation; and be it further

RESOLVED, that this Patient Protection Study Committee be directed to report to the KMA House of Delegates at the 1997 Annual Meeting; and be it further

RESOLVED, that the Kentucky Medical Association, through the Committee on State Legislative Activities, the Legislative Quick Action Committee, and other appropriate bodies, determine to use the report of the Patient Protection Study Committee to develop a Kentucky Patient Protection Act, and to assign it a high priority on KMA's legislative agenda for the 1998 Kentucky General Assembly.

Recommendations, Reference Committee C:

Reference Committee C reviewed Resolution 114, Patient Protection, submitted by the Jefferson County Medical Society and recommends its adoption.

RESOLUTION 96-115

Physician Provider Tax Northern Kentucky Medical Society

WHEREAS, the Kentucky Medical Association has long-standing policies and principles condemning the use of a physician provider tax as a method of financing the Medicaid program; and

WHEREAS, the KMA and its leaders were advised by the Governor, the Lieutenant Governor, and key legislators that immediate repeal of the physician provider tax would jeopardize the fiscal stability of the Commonwealth; and

WHEREAS, the Governor has acknowledged that the physician provider tax is unfair and counterproductive; and

WHEREAS, the provider tax directly affects physicians, and the KMA is the primary advocate for all of its physician members in the Commonwealth; and

WHEREAS, the KMA has advocated for adequate reimbursement for physician services in the Medicaid program, and those concerns were addressed in the approved budget of 1996-1997 exclusive of any budget surplus; and

WHEREAS, the Commonwealth of Kentucky announced a \$64 million surplus for the fiscal year 1995-1996; now, therefore, be it

RESOLVED, that the Kentucky Medical Association request Governor Paul Patton advocate to the Legislature the immediate repeal of the health care provider tax on physicians because such action is consistent with the following facts:

1. Paul Patton promised at the KEMPAC dinner of 1995 to immediately repeal the provider tax on doctors because general fund dollars were available in the budget.
2. Paul Patton later appealed to doctors to permit a phase-out of the physician provider tax due to projected budgetary shortfalls and to prevent cuts in other programs.

3. Paul Patton called the provider tax unfair and counterproductive.
4. The Commonwealth of Kentucky announced a \$64 million budgetary surplus at the end of fiscal year 1995-1996; and be it further

RESOLVED, that the Kentucky Medical Association state that the most appropriate use of the 1995-1996 state budget surplus is the immediate retirement of the physician provider tax, and inform the Governor, the executive branch leaders, and the Legislature of this policy.

Recommendations, Reference Committee C:

Reference Committee C considered Resolution 115, Physician Provider Tax, submitted by the Northern Kentucky Medical Society. There was extensive discussion by representatives of the Northern Kentucky Medical Society, members of the Board of Trustees and others. The committee felt that since the provider tax was considered in a special meeting of the KMA House of Delegates and extensive negotiations occurred between the governor and the KMA; an appropriate result was achieved. The point was made that the discovery of a surplus after KMA's negotiations with the governor is a new circumstance which justifies again raising the issue. However, the general feeling was that the adoption of this resolution would be inflammatory and that KMA might not be well served by adoption of the resolution because the existing provider tax could potentially be preserved and not eliminated as planned. Reference Committee C recommends Resolution 115 be rejected.

Steve Woodruff, MD, representing Northern Kentucky Medical Society, indicated that his constituents were still very concerned with these issues. However, they recognized the importance of compromise and presenting a unified front for medicine. The Northern Kentucky Medical Society therefore recommended rejection of the resolution.

Resolution 115 was rejected.

RESOLUTION 96-120

Pharmaceutical Manufacturers' Link to Managed Care Fayette County Medical Society

WHEREAS, major drug manufacturers over the last two years have acquired managed care businesses called pharmaceutical benefit managers (PBMs) that enable them to gain unfair advantages in the market; and

WHEREAS, the General Accounting Office determined that competing drugs of the parent company are dropped from the preferred lists of health plans in favor of the parent companies' drugs; and

WHEREAS, the three largest PBMs are owned by pharmaceutical makers, enabling them to give preferential positioning of their products and causing limits on the ability of the patient to receive the medication the treating physician may recommend; and

WHEREAS, the American Medical Association has developed policies to support physicians being able to prescribe drugs in the best interests of their patients; now, therefore, be it

RESOLVED, that the KMA supports AMA policies that retain appropriate drug prescribing as determined by physicians; and be it further

RESOLVED, that the KMA introduce a resolution at the AMA House of Delegates calling for the AMA to continue to monitor the status of pharmaceutical benefits managers (PBMs) and continue to advise appropriate private and governmental agencies of any practices by PBMs which are inconsistent with AMA policy.

Recommendations, Reference Committee C:

Reference Committee C next reviewed Resolution 120, Pharmaceutical Manufacturers' Link to Managed Care, submitted by Fayette County Medical Society. The committee noted that this is already a policy of the AMA. However, the AMA may not have sufficient manpower assigned to oversee developments on this issue and it may become a larger problem in the future. The committee recommends revision of the resolution as follows:

RESOLVED, that the KMA introduce a resolution at the AMA House of Delegates calling for the AMA to continue to expand personnel to monitor the status of pharmaceutical benefits managers (PBMs) and continue to advise appropriate private and governmental agencies of any practices by PBMs which are inconsistent with AMA policy.

Reference Committee C recommends adoption of Resolution 120, as amended.

Nat Sandler, MD, Lexington, moved that the reference committee's amended Resolved be revised by deleting the words "personnel to" and

adding "ing" to the word "monitor" followed by "of." The Resolved would then read:

"RESOLVED, that the KMA introduce a resolution at the AMA House of Delegates calling for the AMA to continue to expand personnel to monitoring of the status of pharmaceutical benefits managers (PBMs) and continue to advise appropriate private and governmental agencies of any practices by PBMs which are inconsistent with AMA policy."

A motion was made, seconded, and carried to adopt the revised version of the reference committee amendment. Resolution 120 was then adopted as amended from the floor of the House.

The report of Reference Committee C was adopted as amended.

Mr Speaker, I recommend the adoption of the Report of Reference Committee C as a whole, as amended.

Mr Speaker, I want to personally thank the members of Reference Committee C who have attempted to assist this House of Delegates to try to formulate equitable policies on some very worthy, but controversial issues. Members of the Committee are Uday V. Dave, MD, Madisonville; Charles G. Nichols, MD, Pikeville; Brian E. Ellis, MD, Danville; Lela C. Maynard, MD, Pikeville; and Edward L. W. Scofield, MD, Louisville. I also want to personally thank Ms Pam Wethington for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE C
Daniel E. Kenady, MD, Lexington, Chair
Uday V. Dave, MD, Madisonville
Brian E. Ellis, MD, Danville
Lela C. Maynard, MD, Pikeville
Charles G. Nichols, MD, Pikeville
Edward L. W. Scofield, MD, Louisville

Report of the Chair

KEMPAC Board of Directors

Kentucky medicine has weathered a tremendous storm the past two and one-half years. Provider taxes, Medicaid cuts, and so-called health care reform have dominated our professional lives during these dark days. I have serious doubts that had a pollster been among us just one short year ago, if many of us would have honestly forecasted the unbelievable 1996 Kentucky General Assembly success we enjoyed. Those outside the profession and the Association still express amazement that we were able to achieve the victories — phase out the tax — raise Medicaid reimbursement — and strike most of the onerous provisions of HB 250. Many legislators and lobbyists claim that SB 343, the so-called cleanup of HB 250, really only served physicians concerns and for the most part, important provisions of HB 250 were sustained.

Resolution 96-103 even notes the monetary value resulting from KMA's legislative action accruing to each physician in Kentucky regardless of whether he or she is a member of this Association. As Secretary-Treasurer with an abiding interest in membership growth and retention, I have enormous interest in the General Assembly and our legislative program. In my role the past two years as Chair of KEMPAC it has been my pleasure to work side by side with Don Barton, our National Legislative Chair, and Wally Montgomery, KMA's State Legislative Chair. There was no question during those dark days that we had a political problem. Reason — logic — truth — all the facts in the world — tragically have little impact in politics. Many of us recognized, particularly after the 1994 Congressional and State Session that it was time for physicians to exercise raw political power — both within — and without.

Medicine's political arm is KEMPAC. Despite the protestations of non-KEMPAC members that they "contribute" directly to Kentucky General Assembly candidates rather than joining the PAC — the facts simply don't support that premise. The dollar amount contributed by KEMPAC to state candidates generally matches the grand total given independently by the 6,000+ non-KEMPAC member physicians in Kentucky.

The joint effort of the State Legislative Committee, Public Education Committee and KEMPAC served us well in 1996. We will face an equally difficult Session of the General Assembly in 1998 and it is important that each of us lend our support to our Political Action Committee.

We are pleased to report that KEMPAC has established another member-



ship record in 1995-96. We have 1,064 members, a 6% increase over our record breaking 1994-95 year. For the second straight year we are recipients of an award from AMPAC for the efforts we have made. That's the good news.

The bad news is that only one in seven Kentucky physicians belong to KEMPAC, the political arm of organized medicine in Kentucky. We will continue to urge physicians to join and participate in the elective process.

While 1,000 members have done an outstanding job, the fact is one in seven can no longer carry the day for a profession and organization under blistering attack from the media and liberal groups.

Your KEMPAC Board approved contributions of \$33,250 back in April. Yesterday morning the Board approved additional contributions in excess of \$40,000. These contributions are visible reminders to both our supporters and our detractors that we are dead serious about politics in Kentucky and that we will continue to defend the physician/patient relationship and the maintenance of the medical profession in the state and in this country.

In the coming year KEMPAC will increase its visibility within the profession and will be out on the circuit throughout the state conducting meetings to encourage political action. We need your help and support.

Thank you Mr Speaker. This concludes my report.

**William P. VonderHaar, MD
Chair**

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE D

David J. Bensema, MD, Lexington, Chair

28. Report of the Committee on Medical Insurance and Prepayment Plans
29. Report of the PRO Advisory Committee
30. Report of the Committee to Investigate Changing Trends in Medicine
31. Report of the Physician Organization Study Committee
32. Report of the Young Physicians Steering Committee
33. Report of the Resident Physicians Section
34. Report of the Medical Student Section
- Resolution 105 — "Gag" and "Hold Harmless" Clauses in Managed Care Contracts
(Board of Trustees)
- Resolution 106 — The UNISYS Debacle
(Board of Trustees)
- Resolution 107 — Managed Care Organization
(Board of Trustees)
- Resolution 123 — Guidelines for Ordering Home Health, Rehabilitation, and Ancillary Services
(Fayette County Medical Society)
- Resolution 127 — Availability of Laboratory Services
(Board of Trustees)

ITEMS FOR CONSENT

Reference Committee D reviewed the following items and recommends they be filed, by consent of the House, without discussion:

28. Report of the Committee on Medical Insurance and Prepayment Plans — filed
29. Report of the PRO Advisory Committee — filed
30. Report of the Committee to Investigate Changing Trends in Medicine — filed
31. Report of the Physician Organization Study Committee — filed
32. Report of the Young Physicians Steering Committee — filed
33. Report of the Resident Physicians Section — filed
34. Report of the Medical Student Section — filed

Mr Speaker, Reference Committee D recommends adoption of the Consent Calendar as a whole.

Reference Committee D would like to express its appreciation to the

authors of the reports which have been filed for their time and effort spent in gathering this information for the House of Delegates.

Report of the Committee on Medical Insurance and Prepayment Plans

The Committee on Medical Insurance and Prepayment Plans devoted its attention this year solely to changes to and renewal of the KMA group health insurance program sold by Blue Cross and Blue Shield. Close review of the program was necessary because of changes in health insurance laws occasioned by the passage of SB 343, which modified the old HB 250 from the 1994 session of the Kentucky General Assembly.

KMA was markedly successful in helping to change HB 250 to delete or modify provisions onerous to medical practice. Revisions to that bill, however, caused significant changes in insurance requirements which resulted in much uncertainty. The uncertainty arose from the fact that implementing regulations were not available to insurers for them to modify their own operations and rates to accommodate the changes in time to meet renewal deadlines for many policyholders. The anniversary date for the KMA plan occurred during this transition period.

Some of the portions of HB 250 that were retained were supported by KMA. These included guaranteed renewability of health benefit plans, guaranteed issue with a 12-month residency requirement, portability of health insurance between episodes of employment, retention of insurance group rating methods for "eligible associations," provision of authority to the Commissioner of Insurance to appropriately monitor the health insurance industry, and retention of the "any willing provider" language of the previous bill.

Under the previous legislation, several groups joined together to petition the former Health Policy Board to allow continuation of the category of "eligible association." Under this rule, a trade or professional association could qualify for individual group rating even though each of its "members" might be a separate subgroup, such as a physician's office, family, and staff. This issue was being debated at the time that SB 343 passed, and the association category was included in the new bill.

Under the current legislation, all groups that are not self-insured are billed for insurance on the basis of a "modified community" rating system. This means that all groups' rates must be based on a statewide average, and these rates can only be modified or qualified based on gender or industry. The KMA group rate is based on claims experience, which produces a lower rate than the general "modified community" rate. The negative aspect of these changes was that insurers were required, because of the timing of the new law's implementation, to develop premium rates based on actuarial projections, or "guesses." The further result has been that the number of carriers offering insurance in Kentucky has significantly dwindled.

The KMA group rate experienced an increase, partly attributable to the rating period, which is normally 12 months. However, because of a conflict between the group renewal date and the effective date of the law, the premium was based on a 10-month period rather than the normal 12 months, which obviously includes two additional months' claims exposure.

Each of these events was followed closely and expectantly. Finally, the KMA group plan was renewed with some concern about the future of the insurance market in the state. Because of all these factors, the committee instructed the KMA Insurance Agency and its consultants to seek other insurance resources. This has been a difficult task in the diminished insurance market.

The committee will continue to keep a close watch on this situation with the best interest of the KMA group in mind.

**Donald R. Neel, MD
Chair**

Report of the PRO Advisory Committee

The PRO Advisory Committee and the profession have witnessed a significant evolution in the Professional Review Organization (PRO) program since it began in the 1970s from a process to monitor and serve as a watchdog of physician practice, to a vector to positively influence delivery of care.

The PRO process began with what was, essentially, retroactive utilization review. The most recent signal effect of that form of review in memory was the quality of care severity levels. Those sanctionary actions attempting to affect medical performance after the fact did not prove to be effective. Instead a negative, and often adversarial, reaction resulted on the part of the profession, and little comprehensive positive effect was had on care. In spite of the intent, that form of review remained directed at what was, practically speaking, isolated episodes of review.

The stated goal of the PRO program has always been to identify and try to improve issues of quality of care delivery. As noted, those efforts have not always been perceived as physician friendly.

In the past recent years, the PRO program has focused on what has been called the "Health Care Quality Improvement Program," which has been directed at specific entities or diagnoses. The intent here has been to try to improve medical treatment generally and to achieve "best outcomes." Instead of looking at individual incidences of care, the PRO has channeled its efforts into developing plans for improvement of processes and outcomes which, ideally, would be shared with physicians, hospitals, and beneficiaries. This was an effort to achieve systematic improvement of the overall health care delivery process.

The PRO program never accomplished total review or review of all claims, but rather random review of individual diagnosis claims and random review of a given percentage of all cases. Currently, the PRO has ceased random selection of inpatient cases (July 1995) and HMO cases (January 1996). Random selection of ambulatory cases ceased in July 1996.

Beginning at the end of September of this year, the PRO will continue to perform specific review on the following types of cases, of which the membership should be aware:

- Antidumping violations
- Assistance at cataract surgery
- Beneficiary complaints
- Potential concerns identified during project data collection
- Hospital-requested, higher-weighted DRGs
- Hospital-issued notices of noncoverage
- Referrals from other entities

Review of these issues will constitute approximately 100 cases for review, per month, for Kentucky and Indiana combined. The current PRO contractor, Health Care Excel, is designated as the review agent for both states.

Another recent effort undertaken by the PRO has been to develop guidelines for physicians for "best outcomes" for specific diseases. The PRO has impeded physicians and other related personnel to formulate these guidelines on such issues as chronic obstruction pulmonary disease and smoking cessation.

The future of the PRO program remains uncertain. Major revisions to the Medicare program that will likely occur in the next Congress will undoubtedly promote managed care processes which may obviate the need for a PRO. We will continue to monitor these issues and keep the membership informed.

William H. Mitchell, MD
Chair

Report of the Committee to Investigate Changing Trends in Medicine

The growth of managed care in the United States has been significant. HMO enrollment has grown from 6 million in 1976 to 50.2 million in 1995. The trend today is to shift the financial risk to the provider through discounts, thresholds, and capitation. This changing dynamic is presenting new challenges to medicine where the traditional patient/physician relationship is now being influenced and sometimes controlled by contract-imposed restrictions.

The ideal patient/physician relationship is based on the patient's trust that physicians are committed — first and foremost — to serving the needs of the patient. Trust is the foundation of the ethical elements of that relationship. Very few patients know how much or how little medical services they need. They rely on their physician for professional advice on such matters. Society expects that the physician's care of a patient and concern for the patient's well-being will supersede the physician's own personal interest, especially financial interest.

Many Americans consider choice to be a critical dimension for the ideal patient/physician relationship, to include: choice of practice type and setting, choice of primary care physician, choice of specialist or special facility in an emergency or for a special condition, and choice of treatment alternatives.

Patients also expect their physician to be competent. This includes the physician's medical knowledge, technical skills, clinical judgment, and an understanding of his/her own limitations with a willingness to consult specialists or other providers as required by the situation.

The ideal relationship also relies on good communication. Patients expect their physician to listen and understand them and to communicate that understanding. Patients also want their physician to be compassionate and empathetic. Empathy enables patients to feel supportive during times of stress and uncertainty. Once established, a patient's relationship with the physician should endure over time.

While this ideal relationship is desirable by, and attainable from, both the patient and physician, it's quickly becoming less prevalent as managed care companies restrict choices, limit options, and change provider panels frequently — all in the name of cost savings or efficiency, which typically translates to shifting health care dollars to corporate profit.

In medicine, our technological and scientific developments have outpaced society's ability to pay for health care. We, as a society, will never be able to afford all the health care we need. The very concept of insurance arose from that circumstance as individuals pooled resources to protect themselves from financial hardships of unanticipated illness or trauma. Today, that concept has changed from one of shared risk to that of shifted risk.

To realistically consider the ethical issues of managed care, however, we must first realize that no payment system is void of financial self-interest. Fee-for-service medicine may encourage more services than necessary; capitation, the opposite.

In a fully risk-taking managed care system, physicians are expected to balance the interest of their patients with the interest of other patients. In addition, managed care can place the needs of patients in conflict with the financial interest of their physician, since costs for any services rendered must come from the pre-paid capitation pool.

While some cost containment may be achieved through eliminating waste and increasing efficiency, it is also achieved by limiting access to services, especially to tests or procedures demonstrated to produce only a small or uncertain benefit or a likely benefit at a great expense. Since investor-owned managed care plans usually work in a limited budget with a priority on reporting favorable results to shareholders, the cost of the service will often influence whether the service is offered to patients who might benefit from it, such as in the case of a bone marrow transplant.

Eliminating inappropriate services can reduce expenditures and improve the quality of life. Reducing expenditures can limit desirable services and decrease the quality of life for the patient.

Using protocols may eliminate some clinical errors and enable physicians to spend more time with patients. Relying on protocols could lead to poorer medicine, especially in complex or uncertain cases.

Coordinating activity can lead to greater efficiency and expand the use of services. Increasing efficiency could result in patients receiving less individual attention.

According to the AMA Council on Ethical and Judicial Affairs, the physician is obligated to provide or recommend treatment when the physician believes that the treatment will materially benefit the patient and not to withhold the treatment to preserve the plan's resources. Physicians must insure that all medically relevant information is considered and that no group of patients are put at an unfair disadvantage.

Physicians should disclose all available treatment alternatives regardless of cost, including those potentially beneficial treatments that are not offered under the terms of the plan. Obligations of disclosure always apply to the physician practicing in managed care plans.

It is also critical for managed care plans to have a well structured appeals process through which physicians and patients can challenge the denial of a particular diagnostic test or therapeutic procedure. Appeal mechanisms for treatment denials are essential because policy allocation decisions can never fully account for all contingencies and will sometimes underserve individual patients. The physician's duty as patient advocate requires not only a challenge to any diagnostic treatment from the guide-



lines, but also advocacy at the health plan's policy making level to seek elimination or modification of the guidelines.

The AMA Council on Ethical and Judicial Affairs has issued the following guidelines regarding physicians who practice in a managed care environment.

1. The duty of patient advocacy is a fundamental element of the physician/patient relationship that should not be altered by the system of health care delivery in which physicians practice. Physicians must continue to place the interests of their patients first.
2. When managed care plans place restrictions on the care that physicians in the plan may provide to their patients, the following principles should be followed:
 - a. Any broad allocation guidelines that restrict care and choices, which go beyond the cost-benefit judgments made by physicians as a part of their normal professional responsibilities, should be established at a policy making level so that individual physicians are not asked to engage in ad hoc bedside rationing.
 - b. Regardless of any allocation guidelines or gatekeeper directives, physicians must advocate for any care they believe will materially benefit their patients.
 - c. Physicians should be given an active role in contributing their expertise to any allocation process and should advocate for guidelines that are sensitive to differences among patients. Managed care plans should create structures similar to hospital medical staffs that allow physicians to have meaningful input into the plan's development of allocation guidelines. Guidelines for allocating health care should be reviewed on a regular basis and updated to reflect advances in medical knowledge and changes in relative costs.
 - d. Adequate appellate mechanisms for both patients and physicians should be in place to address disputes regarding medically necessary care. In some circumstances, physicians have an obligation to initiate appeals on behalf of their patients. Cases may arise in which a health plan has an allocation guideline that is generally fair but in particular circumstances results in unfair denials of care, ie, denial of care that, in the physician's judgment, would materially benefit the patient. In such cases, the physician's duty as patient advocate requires that the physician challenge the denial and argue for the provision of treatment in the specific case. Cases may also arise in which a health plan has an allocation guideline that is generally unfair in its operation. In such cases, the physician's duty as patient advocate requires not only a challenge to any denials of treatment from the guideline, but also advocacy at the health plan's policy making level to seek an elimination or modification of the guideline. Physicians should assist patients who wish to seek additional, appropriate care outside the plan when the physician believes the care is in the patient's best interests.
 - e. Managed care plans must adhere to the requirement of informed consent that patients be given full disclosure of material information. Full disclosure requires that managed care plans inform potential subscribers of limitations or restrictions on the benefits package when they are considering entering the plan.
 - f. Physicians also should continue to promote full disclosure to patients enrolled in managed care organizations. The physician's obligation to disclose treatment alternatives to patients is not altered by any limitations in the coverage provided by the patient's managed care plan. Full disclosure includes informing patients of all their treatment options, even those that may not be covered under the terms of the managed care plan. Patients may then determine whether an appeal is appropriate or whether they wish to seek care outside the plan for treatment alternatives that are not covered.
 - g. Physicians should not participate in any plan that encourages or requires care at or below minimum professional standards.
3. When physicians are employed or reimbursed by managed care plans that offer financial incentives to limit care, serious potential conflicts are created between the physicians' personal financial interests and the needs of their patients. Efforts to contain health care costs should not place patient welfare at risk. Thus, financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care.
 - a. Any incentives to limit care must be disclosed fully to patients by plan administrators on enrollment and at least annually thereafter.

- b. Limits should be placed on the magnitude of fee withholds, bonuses, and other financial incentives to limit care. Calculating incentive payments according to the performance of a sizable group of physicians rather than on an individual basis should be encouraged.
 - c. Health plans or other groups should develop financial incentives based on quality of care. Such incentives should complement financial incentives based on the quantity of services used.
 4. Patients have an individual responsibility to be aware of the benefits and limitations of their health care coverage. Patients should exercise their autonomy by public participation in the formulation of benefits packages and by prudent selection of health care coverage that best suits their needs.

As physicians, we assume significant responsibility for the physical well-being of those who have chosen us to care for them. We have long been accountable for the clinical and scientific aspects of care. Most physicians have felt compelled to be sensitive to our patients' emotional well-being as well. Now, we are asked to assume financial risk though withholds and capitation. We are told we have little choice but comply because there are plenty of others willing to accept these terms.

While we sometimes face pressures from financial rather than medical priorities, we need to remember that the well-being of our patients far outweighs financial considerations, particularly those of managed care companies whose only contact with the patient is to collect the premium.

**Majorie R. Fitzgerald, MD
Chair**

Report of the Physician Organization Study Committee

The Physician Organization Study Committee was formed after the adoption of Resolution B by the 1993 Kentucky Medical Association House of Delegates. Resolution B called for the Kentucky Medical Association to:

1. Initiate a study of the feasibility of establishing a physician-owned and directed economic entity which allows all KMA members the opportunity to participate in delivery and payment systems evolving from health system reform measures;
2. Consider legal, professional, and financial requirements of establishing a physician-owned and directed economic entity, as well as the corporate structure, philosophy, and future relationships with KMA and affiliated organizations;
3. Engage the services of appropriate consultants, as required, to help determine the advisability of such an organization, as well as levels of professional and financial support deemed necessary to assure fiscal viability.

During its several years of existence, the committee met on numerous occasions to develop and fine tune a plan of action. As previously reported to the House of Delegates, the committee developed the following short-term action plan and reaffirmed same in 1995:

1. Publicize AMA's Doctors Resource Service (DRS), which was designed by AMA specifically for physicians involved or considering involvement in managed care.
2. Make committee members and staff available to speak to interested groups of physician members across the state. Staff could develop the text and some accompanying slides. (It should be noted that a presentation has been developed and presented to various physician groups throughout the state.)
3. Begin research on the status of managed care, physician organizations, and nonphysician organizations in Kentucky. There is no central source of information readily available currently.
4. Influence the market in Kentucky by helping to influence the structure that is negotiated by recommending physician-friendly firms (legal, financial, business, actuarial consultants) to perform certain services. KMA can serve as a central reference point to put doctors together with competent advisors.
5. Sponsor managed care seminars on a statewide, regional, or local basis using consultants interviewed and "endorsed" by KMA.

The committee has made every effort in the past year to comply with this comprehensive plan. In fact, extensive efforts have gone into implementing all five facets of the plan of action. These efforts were highlighted by the presentation of a joint KMA-AMA interactive managed care workshop/

forum in Lexington in November. This workshop was well-attended and provided many Kentucky physicians with much needed information regarding managed care. The Lexington workshop/forum complemented and expounded on similar presentations made in the last several years in Richmond, Louisville, and Paducah. The committee is currently planning another full day workshop/forum on managed care for later this fall. This educational offering should expand upon previous committee educational efforts and provide physicians with the latest managed care developments and information.

Among the long-term goals reaffirmed by the committee in 1995 were:

1. Explore ongoing educational activities, to include quality assurance and outcomes measurement; development and ongoing refinement of practice parameters, utilization review, and appropriate CME opportunities.
2. Explore arrangements which might offer some benefits of a physician organization without the financial commitments required by some types of physician organizations (ie, partnerships, joint ventures).

In regard to these long-term goals, the committee continued to work with all available groups (ie, AMA, Kentucky Health Policy Board, Kentucky Department of Medicaid Services, outside consultants) to meet these objectives.

Other issues of importance that highlighted the committee's year included the concept of converting Kentucky's Medicaid program to managed care. CHR representatives met with the committee to explain the Medicaid managed care proposal. In this plan, "health care partnerships" would be set up in various regions of the state. These partnerships would design the Medicaid delivery system for their individual region and design payment methodology. Current plans call for two of the regions to become operational in 1997.

During the past several months, the committee has been intricately involved in the discussions relating to the formation of a KMA-sponsored PPO to provide physician services to Kentucky Kare, the state's self-funded health plan for state employees. It was the consensus of the committee that KMA move forward with formation of a statewide PPO. This PPO would be wholly owned by KMA. The PPO's Board and committees would be composed of KMA member physicians and its intent would be to offer KMA members an opportunity to compete with insurance carriers and hospitals from a position of strength. The characteristics of the PPO relative to the services to be rendered to Kentucky Kare enrollees consist of:

- The reimbursement rates and benefits for Kentucky Kare recipients are fixed by the state. Physicians who provide care to these enrollees would have a simple decision to make to contract with an insurance company or hospital organization abiding by their policies, procedures, and protocols, or to participate in a physician-directed organization sponsored by the KMA abiding by the policies, procedures, and protocols developed by physicians.
- All utilization review procedures, including precertification, will be consistent with those currently being performed on all Kentucky Kare enrollees.
- This would be a fee-for-service, open access plan. Physicians would be asked to sign a participating agreement requiring acceptance of the Kentucky Kare fee as payment in full with no balance billing of the patient. There is no financial risk to the physician (ie, capitation or fee withholds) and no gatekeeper. Any physician meeting the requirements of the PPO would be allowed to participate.

Last year the committee recommended that KMA not develop an insurance-based entity. This recommendation still stands this year. The challenge of setting up an insurance-based physician organization is formidable. It is expensive to establish. No matter how much physician support is given these entities, they will still have the general characteristics of insurance companies. They will need to market their product to the buyers, requiring sales representatives and other marketing assistance. They will need a way to collect and distribute money, requiring administrative assistance, computers, and management personnel. They will need a way to judge that the premiums paid will be enough to meet their financial obligations, which means hiring actuaries and building reserves in addition to generating enough funding to cover initial start-up costs. Despite these obstacles, the committee continues to explore and study this option for future consideration by KMA.

This has been an active year for the committee, and I foresee 1997 as no different. The committee will continue to study and explore methods to

meet the charge of Resolution B (1993). There is a window of opportunity for Kentucky physicians to have some control over their futures in a managed care environment. Keep in mind that only physicians are licensed to practice medicine and, therefore, they will be a major player in all emerging health care delivery systems. The committee will continue its efforts to help KMA develop the best available means to meet this goal.

As Chair, I appreciate the active participation of the members of the committee and their commitment to the committee's goals and responsibilities.

Robert R. Goodin, MD
Chair

Report of the Young Physicians Steering Committee

The Young Physicians Section (YPS) of the Kentucky Medical Association was established for members 40 years of age or younger or who have been in practice 5 years or less. While most issues affecting young physicians are universal to all doctors, there are some matters that are unique to younger members of the profession.

This year the Steering Committee of the Young Physicians Section considered some of the concerns which probably have more influence on the practice of young physicians and, in some instances, constitute actual barriers to practice. These include workforce planning, volume indicators under managed care, and practice opportunities.

In the area of workforce planning, it was noted that the number of residency positions in the United States has increased over previous years, while medical school admissions have not. This disparity is caused partly by physician workforce demand. A result, however, is that many residency slots obviously are not being filled by US-trained students. At the national level, it is felt that residency positions should be reduced to more closely conform to medical school output. However, residency positions should be filled on the basis of merit, and not solely because of medical school nationality.

The use of "volume indicators" by managed care companies is a process where physicians, particularly young doctors, may not be allowed to participate in a managed care plan, or may have their practice restricted, unless a minimum number of given procedures have been performed. This works to the distinct disadvantage of a young, rural physician, for example, who may be the main attending physician for every instance of a given diagnosis in a hospital in a rural area, but who would have been engaged in less than the number of required cases.

Practice opportunities in a given local, or even regional, area may be determined by the proliferation of managed care plans, particularly where they dominate a local market. Young or new physicians may not have access to a patient base simply because of their specialty, and regardless of skill and training. Given specific provisions of some managed care contracts, some medical specialties may be excluded altogether.

All of these issues were given close consideration also at the AMA level through its Young Physicians Section. Previously, a member of the KMA-YPS, Bruce A. Scott, MD, was elected as a Member-At-Large of the Governing Council. At the past meeting in June, Dr Scott was elected as the YPS Delegate to the AMA House of Delegates, representing all young physicians who are members of the AMA. This also translates into providing Kentucky with an additional voice in the House, and we are quite proud of Dr Scott and his accomplishments.

Plans were also finalized for the annual luncheon meeting of the YPS during the KMA Annual Meeting. A luncheon will be held on Friday, September 27, at a location to be announced, and several timely topics are being considered to headline the meeting. This year's plans also call for an opportunity for all physicians to become involved in networking with their peers.

The YPS plans to hold a separate, annual organizational meeting beginning in the 1996-97 Associational year. At this meeting, we will solicit input on specific directions and develop issues to address, hold elections, and consider more direct representation of our views to the KMA.

On behalf of the Young Physicians Section and all young physicians in the state, I would like to thank the Board of Trustees for their support and the members of the Steering Committee for all their efforts.

W. Ford Threlkeld, MD
Chair



Report of the Resident Physicians Section

The Resident Physicians Section has been very active at the state and national levels during the past year. The Governing Council, made up of representatives from the four residency programs in the state, met four times this year and has had strong representation at the KMA Annual Meeting as well as the AMA Interim and Annual Meetings.

The section was pleased to sponsor, along with the KMA Medical Student Section, its fifth joint Annual Meeting program on September 19, 1995, at the Lexington Civic Center. "Managing to Care in a Managed Care Environment," featured a prominent panel of speakers: Richard Clover, MD, Chair, UL Department of Family Medicine; Beverly Gaines, MD, Kentucky Health Policy Board member; James Hartert, MD, Chief Medical Officer, Humana Health Care Plans of KY; and William Vonderhaar, MD, KMA Secretary-Treasurer and Chair, Judicial Council. A lively and spirited interchange took place with students and residents on the future direction of medicine in the managed care arena.

The KMA-RPS was fortunate to be the recipient of two AMA Policy Promotion Grants this year. The September 19th Annual Meeting symposium was awarded \$500 and a second \$500 grant was awarded to the KMA-RPS for distribution to the Girl Scouts Wilderness Road Council for its First Aid for Children Today Program. The KMA-RPS participated in the AMA Girl Scout Mentoring Program through council member Donna Skinker, MD.

KMA was well represented on many fronts at the national level. UK resident Judy Linger, MD, just completed her term as Chair of the AMA-RPS Governing Council at the June Annual Meeting. In addition, UL resident Robin Floyd, MD, was one of 25 residents in the nation to receive the AMA/Glaxo Wellcome Achievement Award in recognition of exceptional leadership abilities in medicine.

The council, at its February meeting, heard an overview of 1996 legislative activity by Don Chasteen, KMA Public Affairs Director, and were encouraged to get involved in the political process at the state level. New officers were elected in March and tentative plans made for the upcoming AMA and KMA Annual Meetings. The July 16th meeting reviewed plans for the RPS and MSS Annual Meeting to be held September 27, 1996, and featured reports from the 1996 AMA-RPS Annual Meeting held in Chicago.

In late June, KMA once again participated in the Housestaff Orientations at UK and UL. Dr Skinker spoke individually with incoming residents at UK on June 25 and Dr Floyd and Robert R. Goodin, MD, KMA Immediate Past President and AMA Delegate, were program speakers at UL's Orientation on June 28. Over 90 residents joined the Association through these efforts. We are grateful to the speakers as well as to the residency programs for the opportunity to encourage residents to get involved in organized medicine.

I would like to thank the individual members of the Governing Council for their efforts and extra time involved to participate in the quarterly meetings. I appreciate the opportunity to represent the section at meetings of the KMA Board of Trustees and, on behalf of the council, I wish to thank the House of Delegates and members of KMA for their continued support.

Kyle H. Kiser, MD
President

Report of the Medical Student Section

The KMA Medical Student Section has been involved in activities at all levels of the federation this year with strong representation at KMA and AMA meetings. The fifth annual statewide meeting of Kentucky residents and students held September 19 in Lexington was well received. Comments from the panelists who dealt with the coming changes in medicine in a managed care environment sparked a lively debate among the 60-plus attendees.

Presidents and outreach leaders from the two MSS chapters at the University of Louisville and University of Kentucky received Outreach Program Awards at the 1995 AMA Interim Meeting in Washington, DC. Both chapters did an exceptional job this year in membership recruitment, with 66 new members at UK and 84 from UL. These efforts resulted in monetary awards of more than \$3,000 to the chapters from the AMA to assist them in sending students to the AMA meetings.

We are grateful for the opportunity to be involved on several of the committees of the Association and to be asked to serve on the House of Delegates reference committees. The section would like to thank the offi-

cers, delegates, and all KMA members for their support of medical student activities and the opportunity given to us to have a voice in the affairs of organized medicine.

John Bruner, UK President
Matt McDonald, UL President

END OF CONSENT CALENDAR ITEMS

RESOLUTION 96-105

"Gag" and "Hold Harmless" Clauses in Managed Care Contracts Board of Trustees

WHEREAS, contracts between managed care entities and physicians may contain clauses that prevent physicians from discussing certain issues with patients or other health care professionals that may have a bearing on the patient's health, including the consequences of payment decisions by a third-party payer; and

WHEREAS, these so-called "gag" clauses jeopardize the patient-physician relationship and impede the physician's obligation to provide full disclosure of information to patients to enable informed medical decision-making; and

WHEREAS, contracts between managed care organizations and physicians may contain "hold harmless" clauses which may hold the physician legally liable for economic or administrative circumstances which may be beyond his/her control; and

WHEREAS, many managed care entities attempt to enforce these "hold harmless" clauses against physicians when the managed care organization denies payment for or disallows needed medical care to the physician's patient; now, therefore, be it

RESOLVED, that the Kentucky Medical Association urge all Kentucky physicians to consult with legal counsel prior to contracting with a managed care entity to prevent the imposition of unfair liability upon the physician; and be it further

RESOLVED, that the Kentucky Medical Association actively support any and all legislative or regulatory efforts to ban "gag" and "hold harmless" clauses from contracts between managed care entities and physicians.

Recommendations, Reference Committee D:

Reference Committee D reviewed Resolution 105, "Gag" and "Hold Harmless" Clauses in Managed Care Contracts, introduced by the Board of Trustees.

The committee considered recommendations for development of a standard contract. The committee, however, feels that physicians would be best served through educational opportunities provided by the Kentucky Medical Association regarding managed care and their own efforts at negotiating with the various HMO contractors. The committee recommends that Resolution 105 be adopted.

RESOLUTION 96-106

The UNISYS Debacle Board of Trustees

WHEREAS, UNISYS, the state's fiscal agent charged with processing and paying Medicaid claims, assumed the responsibility in December 1995; and WHEREAS, despite being operational for over nine (9) months, payments for physicians' claims continue to be delayed, some as long as 120 days; and

WHEREAS, despite repeated assurances from UNISYS officials, claims are still not being processed in an efficient and timely manner; and WHEREAS, many participating physicians' offices in the Medicaid program are experiencing serious cash flow problems; and

WHEREAS, the Lt Governor of Kentucky, the Secretary for Health Services, and General Assembly Health and Welfare Committees have made Herculean efforts to resolve this problem; now, therefore, be it

RESOLVED, that the KMA House of Delegates recommends that the Commonwealth of Kentucky seek enforcement of the monetary damage provisions available under contract with UNISYS; and be it further

RESOLVED, that liquidated damages, where possible, be made available to pay outstanding claims languishing in UNISYS "pending claims" file; and be it further

RESOLVED, that if UNISYS does not come into compliance with the original contract in the near future that the Commonwealth should seriously consider canceling the contract with UNISYS; and be it further

RESOLVED, that this House of Delegates applauds the efforts made by Lt Governor Stephen L. Henry, MD, Secretary for Health Services John H. Morse, and members of the General Assembly Health and Welfare Committees for working with KMA leadership to reconcile a problem initiated by the previous administration.

Recommendations, Reference Committee D:

Reference Committee D reviewed Resolution 106, The UNISYS Debacle, submitted by the Board of Trustees, and all testimony regarding this resolution including options of changing the wording in the third Resolved to substitute "replace UNISYS with another contractor" in place of "canceling the contract with UNISYS." However, the Reference Committee felt this would be a redundancy and has chosen to keep the resolution as originally worded. Reference Committee D recommends that Resolution 106 be adopted.

RESOLUTION 96-107

Managed Care Organization

Board of Trustees

WHEREAS, the 1993 Kentucky Medical Association House of Delegates adopted Resolution B that called for a study of the feasibility of establishing a physician-owned and directed entity which would allow all KMA members the opportunity to participate in delivery and payment systems evolving from health system reforms and market forces; and

WHEREAS, as a result of Resolution B (1993), the KMA Physician Organization Study Committee was formed and has studied the feasibility of forming a KMA-sponsored and directed managed care organization; and

WHEREAS, certain health system reforms and market forces have made the formation of a KMA-sponsored and directed managed care entity a desirable option; and

WHEREAS, a survey of the membership during the summer of 1996 to determine interest in forming a physician-owned and directed managed care organization resulted in 92% of the respondents (Y-1552/N-140) supporting such an undertaking; and

WHEREAS, the Physician Organization Committee has recommended the formation of a KMA-sponsored and directed managed care organization; and

WHEREAS, the KMA Board of Trustees recommends that KMA proceed with all legal and administrative steps necessary to the formation of a KMA-sponsored and directed statewide managed care organization; now, therefore, be it

RESOLVED, that KMA proceed as indicated in a timely fashion to form a managed care organization which would maintain and operate a physician-owned and controlled network of physicians open to KMA members, who in cooperation with other health care providers would contract for and deliver managed health care services. The network will provide high quality medical care that is cost-competitive with other efficiently operated managed care plans in a manner that does not intrude on the medical judgment of physicians or interfere with the physician-patient relationship.

Recommendations, Reference Committee D:

The committee heard extensive discussion regarding Resolution 107, Managed Care Organization, submitted by the Board of Trustees, with specific testimony from Robert R. Goodin, MD, Past President of KMA. The committee recommends that Resolution 107 be amended by adding the words "and be it further" to the existing Resolved, and adding a second Resolved as follows:

RESOLVED, that the KMA maintains as a principle that whenever possible in the negotiation of contracts for health care services, physicians in all regions in Kentucky be compensated equally for equal services.

Reference Committee D recommends that Resolution 107 be adopted as amended.

RESOLUTION 96-123

Guidelines for Ordering Home Health, Rehabilitation, and Ancillary Services

Fayette County Medical Society

WHEREAS, an aging population and changes in the health care environment have led to the increased demand and utilization of nursing home, home health, rehabilitation, and ancillary services; and

WHEREAS, the cost of these services is taking a significant portion of the health care dollar; and

WHEREAS, physicians have the major role in insuring the appropriate utilization of these services; now, therefore, be it

RESOLVED, that the KMA develop or adopt, in consultation with specialty organizations and other appropriate organizations, guidelines for the prescribing and utilization of nursing home services, home health services, and rehabilitation services.

Recommendations, Reference Committee D:

Reference Committee D next considered Resolution 123, Guidelines for Ordering Home Health, Rehabilitation, and Ancillary Services, introduced by the Fayette County Medical Society. The Reference Committee heard supportive testimony for this resolution from a number of individuals. The Reference Committee recommends that the Resolved be amended by replacing the words "specialty organizations" with the word "physicians." The Resolved will then read as follows:

RESOLVED, that the KMA develop or adopt, in consultation with specialty organizations physicians and other appropriate organizations, guidelines for the prescribing and utilization of nursing home services, home health services, and rehabilitation services.

Reference Committee D recommends that Resolution 123 be adopted as amended.

RESOLUTION 96-127

Availability of Laboratory Services

Board of Trustees

WHEREAS, some insurance carriers have designated certain laboratories exclusively for use by participating physicians ordering tests of a given complexity; and

WHEREAS, these laboratories are centrally located or off-site from many service locations; and

WHEREAS, local laboratories may continue to participate and serve local physicians, but at reimbursement rates below cost levels or with otherwise restrictive requirements, thereby virtually proscribing their participation; and

WHEREAS, the lack of availability of local laboratory services constitutes a barrier to continuity of care and may be contrary to patient welfare; and

WHEREAS, this exclusionary process may violate the "any willing provider" provision of state law, now therefore, be it

RESOLVED, that the Kentucky Medical Association adopts the position that local laboratory services should be available to physicians for use by their patients so that results may be promptly available if needed; and be it further

RESOLVED, that the KMA support means (either through legislation and/or arbitration with carriers/payors) that any physician office lab which has met accreditation with CLIA/COLA be accepted as one of their participating "central" labs; and be it further

RESOLVED, that if insurance carriers continue to use exclusive labs, carriers/payors be required to make certifications to physicians that participating "central" laboratories are qualified and adequately proficient to serve the physicians' patients; and be it further

RESOLVED, that the assistance of the Commissioner of Insurance be solicited as appropriate to help resolve this situation and assure the proper application of the "any willing provider" provision of state law.

Recommendations, Reference Committee D:

Reference Committee D next considered Resolution 127, Availability of Laboratory Services, introduced by the Board of Trustees. Reference Committee D heard specific testimony to this resolution from Baretta R. Casey, MD, Pikeville, as well as several other physicians from throughout the state, detailing some of the difficulties engendered by the utilization of centralized laboratories both for their appropriate practice in medicine and for the accessibility for their patients. Based on this testimony, the Reference Committee recommends adoption of Resolution 127.



Mr Speaker, I recommend the adoption of the Report of Reference Committee D as a whole.

Mr Speaker, I want to personally thank the other members of Reference Committee D who have attempted to assist the House of Delegates in formulating policies on some very worthwhile issues. Members of the Committee were: Thomas E. Bunnell, MD, Erlanger; Paul W. Craig, MD, Ashland; Robert C. Hughes, MD, Murray; Kyle H. Kiser, MD, Covington (RPS); and Billy Joe Parson, MD, Somerset. I would also like to thank Ms Denise Scinta for her assistance in preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE D
David J. Bensema, MD, Lexington, Chair
Thomas E. Bunnell, MD, Erlanger
Paul W. Craig, MD, Ashland
Robert C. Hughes, MD, Murray
Kyle H. Kiser, MD, Covington
Billy Joe Parson, MD, Somerset

Editorial Note: Unless otherwise indicated, the Reference Committee recommendation on each Report and Resolution was accepted. Any opposing or additional action taken by the House is printed in discussion following the item.

REPORT OF REFERENCE COMMITTEE E

Robert J. Emslie, MD, Bowling Green, Chair

35. Report of the Committee on Maternal and Neonatal Health
36. Report of the Technical Advisory Committee on Physician Services (Medicaid)
37. Report of the Committee on Community and Rural Health
38. Report of the Committee on Physical Education and Medical Aspects of Sports
39. Report of the Committee on Child and School Health
40. Report of the Judicial Council
41. Report of the Joint Oversight Group on Health Care Reform
42. Report of the Statewide Health Information Network Feasibility Study Committee
43. Report of the Interspecialty Council
- Report of the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan
- Resolution 113 — HIV Testing
(Jefferson County Medical Society)
- Resolution 116 — Partners for Family Farms
(Estill County Medical Society)
- Resolution 117 — AMA-CPT Coding
(Northern Kentucky Medical Society)
- Resolution 121 — HCFA-1500 Form
(Fayette County Medical Society)
- Resolution 122 — Kentucky Lawsuit Against FDA Regulations
(Fayette County Medical Society)
- Resolution 126 — Primary Care Physicians' Treatment of Depression
(Nancy Swikert, MD, President, KAFP)

ITEMS FOR CONSENT

Reference Committee E reviewed the following items and recommends they be filed, by consent of the House, without discussion:

35. Report of the Committee on Maternal and Neonatal Health — filed
36. Report of the Technical Advisory Committee on Physician Services (Medicaid) — filed
38. Report of the Committee on Community and Rural Health — filed
39. Report of the Committee on Child and School Health — filed
40. Report of the Judicial Council — filed
41. Report of the Joint Oversight Group on Health Care Reform — filed
43. Report of the Interspecialty Council — filed
- Report of the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan — filed

Reference Committee E would like to express its appreciation to the chairs and members of these committees for their efforts in dealing with the issues discussed in the reports.

Mr Speaker, Reference Committee E recommends adoption of the Consent Calendar as a whole.

Report of the Committee on Maternal and Neonatal Health

The Committee on Maternal and Neonatal Health continued its mission this year to identify and develop issues of interest to the profession, to share this information with the membership, and to represent the Association to related agencies. Although the committee considered a number of related matters, a few major issues should receive focus.

The issue of substance abuse and related aspects as they pertain to pregnant women and neonates is significant. Earlier, an Ad Hoc Committee on Maternal-Fetal Conflict was appointed to consider an acute legal question surrounding substance abuse; ie, the legal responsibility of the mother for her role in neonatal addiction. The committee reconsidered and would like to underscore its position in that context, which is that, regardless of legal factors, systematic screening of all OB patients for substance abuse programs and referral when appropriate is critical.

Considerable attention was given to methods, not only to accomplish screening, but to encourage practicing physicians to initiate and expand screening vectors. Some patient populations produce as many as 40% of expectant mothers with high-risk factors. Further, it was learned from the state's Department of Maternal and Child Health that last year 20% of all babies were born to teenage mothers. Some of the larger clinics in the state have developed protocols for substance abuse screening which include counseling questionnaires; interview checklists; and in some settings, the routine performance of laboratory screenings unknown to the patient.

Many physicians involved in higher volume maternal and neonatal care are empirically familiar with and adroit about conducting screening for substance abuse. However, information indicates that many physicians are unfamiliar or uncomfortable with providing "cognitive care" of this nature to no benefit to mothers and neonates. The committee urges physicians in affected fields to become knowledgeable about the medical effects of substance abuse and/or appropriate referral indicators and sources.

Of equal significance to mothers and neonates is HIV and other communicable disease screening and treatment. Again, it was found that some hospitals and larger volume care centers have well-established protocols to perform HIV screening. The committee expended some effort in attempting to obtain examples, although confidentiality and proprietary interest have precluded this being done effectively. Hospitals, generally, perform HIV screening through use of the general consent form.

Prenatal treatment for HIV is becoming more and more effective, and it is becoming even more crucial that physicians be better aware of screening modalities and appropriate treatment and referral indicators. There are a number of good educational resources to aid the practitioner, which include materials available through local health departments. Earlier this year the committee requested that some of these resources be published in the *Communicator*, and it is worthy to repeat a list of those materials here. They are:

- Personal Risk Assessment — MCH262
- Handout on who should be tested — MCH263
- General patient information sheet on HIV and AIDS
- Information on what every woman who could be (become) pregnant should know ("For Baby's Sake") — MCH261

Coincidentally, the committee learned that the incidence of HIV false positives during pregnancy is 4 per 100,000 by way of the Western Blot Test. According to state experts, this is not epidemiologically significant (this is a Kentucky-specific figure based on extrapolation).

In order to more widely disseminate information on this matter, the committee encourages physicians to contact local health departments, who are now required to have available an individual capable of providing HIV counseling. Likewise, the attention of the membership is directed to the state newsletter, *Epidemiological Notes*, published by the Department of Epidemiology.

The committee also considered a number of areas where physicians and state medical service components interact through the Medical Assis-

tance Program. An important but under-used portion of Medicaid is the Early Periodic Screening, Diagnosis, and Treatment Program (EPSDT) for children. Established as a direct federal mandate, this program is designed to conduct histories and physicals, TP screening, hemoglobin, nutrition, and safety counseling for eligible children. While there are 275,000 children eligible in the state, only 40,000 per year are routinely tested under its auspices. The state projects that many physicians are accomplishing these same screening efforts but are not signifying them as part of EPSDT. One reason for this may be the relatively low reimbursement, and consequently the majority of EPSDT screenings are accomplished through health departments. Efforts are being made to modify program requirements so paperwork for physicians can be reduced and, hopefully, reimbursement raised.

Another area of concern relating to the Medicaid program has been completion of pap smears. Medicaid will reimburse physicians for performing the examination, but will not provide reimbursement for laboratory analysis. It is the intent of the Kentucky Medical Assistance program to reduce costs by using central laboratory facilities. The end result is, there may be a negative effect on the volume of pap smears completed. The committee is investigating possible changes to this process.

On another issue, the Medicaid program requires that preauthorization be obtained for induction of labor. Seldom, if ever, are such preauthorizations denied. It is the presumed intent of this requirement to reduce the rate of deliveries by Cesarean section. The committee is, likewise, investigating this matter with a concern to make changes.

Following the adjournment of the 1996 session of the Kentucky General Assembly, the committee reviewed legislation particularly affecting maternal and neonatal health. While legislative matters will be addressed elsewhere, the committee did note two bills. The first was HB 186, which requires a minimum hospitalization for normal and Cesarean section. While this and other related legislation are generally positive, the committee members, like most physicians, felt that lengths of stay should be determined by the treating physician in each individual instance of care.

The second piece of legislation of note was SB 258, relating to sexually transmitted disease education. The intent is to prepare one teacher in each school district to receive training on sexually transmitted diseases/life skills issues. Both of these matters have been ongoing concerns of the committee, and the members were strongly supportive of the intent of this bill.

It has been our pleasure to serve the Association this year, and I would like to thank the committee members for their loyalty, general interest, and commitment to the work in maternal and neonatal care issues.

J. Gregory Cooper, MD
Chair

Report of the Technical Advisory Committee on Physician Services (Medicaid)

The Technical Advisory Committee on Physician Services (Medicaid), "Physician TAC," is one of 11 provider groups represented on the Advisory Council for Medical Assistance. The Physician TAC meets as needed to discuss and evaluate problems and concerns faced by physicians when dealing with the Kentucky Medical Assistance Program (Medicaid). If the Physician TAC determines that the issues discussed require action, the Chair presents these issues in the form of a written report to the Advisory Council and makes a formal recommendation for action.

Pursuant to a formal opinion from the Cabinet for Human Resources (CHR) in 1991, all technical advisory committees continue to be subject to the provisions of Kentucky open meetings laws, KRS 61.805-61.850. These laws stipulate that meetings shall be open to the public and shall be scheduled to allow effective public observation and news media coverage.

During the past year, the Physician TAC and KMA nominated physicians to serve on the Drug Formulary Advisory Board (DFAB) and the Drug Use Review Advisory Board (DURAB). Both of these advisory boards are mandated by federal law to serve in an advisory capacity to the Medicaid program. Administrative orders were issued in December 1992 to formulate these advisory boards, and membership on each board includes four physicians selected from a list of nominees provided by KMA. The DFAB advises the Department for Medicaid Services on matters relating to the outpatient drug list, drug prior authorization process, coverage status for new drugs and

other drug-related matters, and makes recommendations to the Medicaid Commissioner concerning the composition of outpatient drug lists. Responsibilities of the DURAB include advising the Department for Medicaid Services on matters relating to drug use therapy, making recommendations to the Medicaid Commissioner on retrospective drug use review standards, developing educational topics on common drug therapy problems and improvement in quality of drug therapy, and establishing standards for identification of suspected fraud and abuse. There is currently ongoing discussion to merge the DFAB and DURAB into one board with the combined board maintaining the same duties and responsibilities as the separate boards.

During the past year, the Physician TAC met formally on one occasion and informally via the telephone and correspondence on other occasions to review concerns expressed by Kentucky physicians about the Medicaid program. The major issues discussed during the course of the year concerned the Medicaid Managed Care Initiative proposed by CHR and UNISYS problems. Both issues were discussed extensively by the Physician TAC.

The Physician TAC will continue its efforts to provide a meaningful forum for Kentucky physicians to present their concerns, suggestions, and ideas in order to provide quality medical services to Kentucky's indigent population.

As Chair, I would like to thank my fellow committee members for the time and effort they expended during this past year. I would like to thank the KMA staff and the Department of Medicaid staff for their assistance throughout the entire year.

A. O'tayo Lalude, MD
Chair

Report of the Committee on Physical Education and Medical Aspects of Sports

The Committee on Physical Education and Medical Aspects of Sports is composed of physician members with an interest in and intense commitment to the physical health, safety, and well-being of children primarily involved in athletics at the high school level and below. All of the members are deeply involved with medical and health issues on an individual basis in their home locations, as well as the voluntary provision of their expertise to schools, coaches, and athletic trainers in their areas. The committee is ably assisted by the Assistant Commissioner of the Kentucky High School Athletic Association, Mr Julian Tackett, and Ms Terry Vance of the Department of Education.

The main focus of the committee this year has been the sponsorship of medical care athletic symposia around the state. As a result of the committee's efforts, the Kentucky High School Athletic Association requires that all school coaches and athletic trainers, where they are employed, receive certification by way of these symposia every two years. This year the committee, through its individual members, sponsored a total of 16 symposia across the state, and final attendance figures are still being compiled. The statutory recognition of athletic trainers and the certification requirements have unquestionably resulted in improved monitoring and care of school athletes and have had a substantial effect on training methods. As newly developed trends in ailments, accidents, and injuries occur, the committee is able to have a direct effect on training and competition changes to meet these new needs.

A further ongoing need for these symposia relates to the somewhat transient nature of coach and athletic trainer employment. Our symposia provide updates on rehabilitation, training, illnesses, frequency and types of injuries, and allow good "hands-on" educational encounters not only for coaches and trainers, but for physicians as well.

At these symposia the committee furnishes to all attendees a Sports Syllabus that was developed under its auspices. Supplies of this syllabus are not depleted, and the committee is seeking sponsors to help defray costs of reprinting. The syllabus constitutes a primer for coaches and trainers and is a good resource document.

This year the committee formed a subcommittee on head injuries that is looking into developing guidelines to prevent, classify, and treat such conditions. An initial difficulty has been the definition of "major injury." Some aspects of the issue that the subcommittee has considered are: ending



play when injuries occur, appropriate ways to enforce rules, the regular revision of rules, and further ways to ensure the presence of trainers and physicians at all school athletic events.

Part of this effort has been to seek some statutory provision and protection for the reporting and collection of injury events. There is an obvious need for such information to be immune from discovery; for a process to develop rules to deal with such injuries; and for appropriate methods to encourage compliance by athletes, referees, coaches, and trainers.

A specific example of a need for this process has been the issue of spear tackling. Spear tackling and blocking have always been a concern in high school athletics, and a presentation on the subject is encouraged at each of the symposia the committee sponsors. In 1976 a rule dealing with spear tackling was adopted nationally for collegiate sports, which has been recognized in all states, and a dramatic decrease in cervical spine injuries has resulted. However, the practice continues with all associated traumas.

It was the committee's feeling that the subject could receive more focused attention if an "official" position could be adopted by KMA. At the April meeting of the KMA Board of Trustees, a statement offered by a member of the committee was adopted, which is as follows:

Head-first tackling and blocking techniques have clearly been shown to increase the risk of serious neck injuries including quadriplegia. It is critical that all referees and coaching personnel continue to educate athletes and enforce current rules which protect against dangerous use of the head.

This formally adopted position was transmitted to the Kentucky High School Athletic Association and subsequently to coaches and trainers. Hopefully, this increased emphasis will result in further reduction of the practice.

The committee followed SB 235 during the 1996 General Assembly. This bill, which relates to athletic trainers, would have imposed severe penalties for violation of the Practice Act through the courts. These penalties would have included monetary assessments as well as incarceration. Athletic trainers are regulated by the Board of Medical Licensure, but under the current statute, sanctions are not specifically defined. These were obviously onerous provisions, and it was gratifying to see that the legislation failed. The committee intends to offer its assistance to the Board of Medical Licensure if further appropriate sanction provisions need to be included in the statute.

As Chair, it is my pleasure and privilege to thank the committee members for their unselfish and very beneficial work.

R. Quin Bailey, MD
Chair

Report of the Committee on Child and School Health

The Committee on Child and School Health met on three occasions during the 1995-96 Association year. Administration of medication and requests — and even requirements — that teachers and school employees perform procedures normally done by nurses and other health professionals are creating concerns. Staff member Joyce Waldrop of the Kentucky Education Association discussed the increasing numbers and complicated medical procedures that school personnel are asked to perform. School personnel believe performing these medical procedures detracts from their teaching time and is an enormous responsibility for which they are not trained. However, federal law requires acceptance of disabled students into the classroom even though many schools are without a school nurse. The Department of Education recommends one nurse for every 750 students; however, there is no legislation or funding mandating this. At this time, each teacher is responsible for his or her own students. The Kentucky Education Association introduced legislation in the 1996 Session mandating more health personnel in the education system. This would include paramedics, EMTs, RNs, LPNs, PAs, etc. However, the legislation failed due to lack of funding resources. It was suggested that the committee ask physicians throughout the state to volunteer their services to local schools. The Wisconsin and Washington State Medical Societies have been contacted for information regarding programs they may have which match physicians with schools for assistance with health care matters. Jefferson County Medical Society was contacted for information on its Adopt-A-Doc program. This committee is discussing initiating an Adopt-A-Doc program as one of its projects.

Terry Vance, committee member representing the Department of Education, presented the committee with a proposed letter from Education

Commissioner Wilmer Cody, PhD, to school superintendents asking their interest in the Adopt-A-Doc project. The intent of the Adopt-A-Doc program is to eventually lead to a contractual agreement between the local physician and the local school. Once responses are received from the school superintendents, letters will be addressed to physicians via the *Communicator*. After much discussion, it was decided that in order to avoid conflict with the AMA program called "Adopt-A-Doc," this committee's program would be called "Adopt-A-Physician." The committee is working with the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan to implement this program.

Lynne Flynn of the Cabinet for Human Resources explained that the Kentucky Early Intervention System (KEIS) and First Steps are the same entitlement program for infants and toddlers with disabilities through age two. This program, which is very family-focused and carries no income requirements, seeks to provide services to meet the needs of these children. Information regarding this program will be filed in the KMA office. A "Smart Card" project being initiated as a means of keeping track of immunizations was also discussed by the committee.

Terry Vance informed the committee that the Department of Education will be adopting a policy on health related activities and will keep the committee informed. The use and abuse of rehabilitation scholarships were also discussed and will be considered in the coming year by the committee.

The committee has completed a very productive year and believes that its ongoing projects and studies will be extremely beneficial to our patients and the profession. The committee appreciates the support of physicians and looks forward to continuing service.

Thomas H. Pinkstaff, MD
Chair

Report of the Judicial Council

Your KMA Judicial Council has met formally on three occasions over the past year and has dealt with many other issues/concerns informally via telephone calls and correspondence.

A major portion of the council's activities during the past year were directed at patient complaints and acting as arbiter on many varied physician activities. Many patient complaints continue to relate to the release and/or transfer of patient records. While it was hoped that the medical records provisions contained in House Bill 250 and House Bill 928 would alleviate many patient complaints in this area, problems still exist. KMA's legal counsel has drafted a summary of the medical records provisions of House Bill 250 and House Bill 928 which has been circulated to all Kentucky physicians and published in the *KMA Journal*. The council recommends that this excellent resource be utilized by physicians when confronted with medical records questions.

Other cases referred to the council included a complaint received from a physician concerning what he perceived to be an unfair credentialing decision by his hospital medical staff peers. This complaint was reviewed and it was determined that since this matter is currently in litigation in a Kentucky court, the Judicial Council will monitor the legal proceedings and not investigate further until the court case is finally concluded. Another case recently received concerns a complaint that a physician provided unnecessary medical services and supplies to a number of his patients. The council continues to investigate this matter and has invited the physician in question to make a personal appearance at its next meeting.

The council continues to receive many complaints and inquiries from patients alleging that their physician was insensitive, uncaring, or rude during an office visit. The council strongly recommends that while a physician should at all times deal honestly and openly with a patient, such communications should be made with compassion.

The council wishes to thank the KMA Board of Trustees for its support and cooperation. Many times over the course of the year, local trustees are called upon by the council to investigate matters in their trustee districts and report their findings back to the council. Without this cooperation, the council could not function effectively.

The council is honored to serve the Association and urges all KMA members to recognize their professional responsibilities and obligations and to adhere thereto.

William P. VonderHaar, MD
Chair

Report of the Joint Oversight Group on Health Care Reform

In 1995, the Joint Oversight Group was established in collaboration with the Kentucky Hospital Association. The KMA/KHA group was established to meet with members of the Health Policy Board to ascertain their goals and plans and in turn, keep the respective memberships fully informed. The Joint Oversight Group provided KMA a conduit through which we presented our positions and proposals up front and provided input prior to the Health Policy Board's final decisions. The group met on several occasions and we believe that the input of the two organizations to the members of the Health Policy Board was useful. Because Senate Bill 343, passed by the 1996 Kentucky General Assembly, repealed the Health Policy Board as well as many other areas of concern to physicians, the Joint Oversight Group has not had further meetings this year, and it is not anticipated that there will be cause for any in the near future.

It is the committee chair's opinion that the committee's work is complete and reappointment is not indicated. However, ongoing communication between the leadership of both groups is of value and it may be useful for the leadership of both organizations to meet periodically on an ad hoc basis in the future.

Ardis D. Hoven, MD
Chair

Report of the Interspecialty Council

The KMA Interspecialty Council has been inactive since 1989. The Board of Trustees directed that the council be reactivated in 1996 and that its mission be to promote and improve communications between KMA and the organized medical specialty groups in Kentucky on medical and socioeconomic issues of mutual interest in an effort to unify and strengthen organized medicine in Kentucky, while maintaining the autonomy of the individual specialty societies. Guidelines for specialty group/society participation on the council were also specified by the Board of Trustees and state that the specialty group/society must have a national or parent organization, must have a formal affiliation with its national counterpart, must be a primary or a major subspecialty in terms of delineated scientific knowledge within the realm of the discipline of medicine, and the representative serving on the council must be a KMA member.

The council held its initial 1996 meeting on February 22, 1996. Twenty-five specialty groups/societies were invited to attend this initial meeting. Most of the discussion at this meeting focused on the AMA Federation Study and its 33 recommendations. It was the consensus of the council to be updated on the status of the Federation Study after the AMA House of Delegates revisits this matter in June 1996.

It is the intent of the council to continue to meet on a regular basis and discuss items of interest in an effort to unify organized medicine in Kentucky.

As Chair, I would like to thank the council members for the time and effort they expended in making the reactivation a success and I look forward to another active and productive year.

Robert R. Goodin, MD
Chair

REPORT OF THE AD HOC COMMITTEE TO DEVELOP A COMPREHENSIVE SCHOOL HEALTH EDUCATION PLAN

The KMA Board of Trustees appointed the Ad Hoc Committee to Develop a Comprehensive School Health Education Plan as a result of the following recommendation by the 1994-95 Committee on Child and School Health:

The Child and School Health Committee reaffirms the KMA House of Delegates' position that health education be taught to all students from kindergarten through the 12th grade. The committee recommends the development of a comprehensive school health education plan of which parenting and family life skills is a facet.

The committee further recommends to the KMA Board of Trustees that an ad hoc committee be formed from individuals in the private sector,

government (including legislative and administrative), and physicians (including members of the KMA Child and School Health Committee and KMA Maternal and Neonatal Health Committee) to study school health education and to present recommendations to the KMA House of Delegates

The 1995-96 Board of Trustees appointed the committee in September 1995, and the committee held its first meeting on December 6, 1995. Terry Vance of the Department of Education gave an overview of the Department's regulations regarding health education. Ms Vance explained the Parenting and Family Life Skills curriculum adopted by the Kentucky State Board for Elementary and Secondary Education in 1989, and its eventual abolishment by the enactment of KERA. She distributed a summary of the curriculum and a portion of 1990 HB 940 (KERA), which states that students will be tested in grades 4, 8, and 12 on several subjects, including health education.

It was suggested that the requirement for teaching family life skills and parenting could possibly be reinstated into the KERA curriculum by the new Education Commissioner since KERA legislation requires that students be assessed in this area periodically. Information was distributed on school health education nationally which listed states which mandate comprehensive school health education. Kentucky remains as one of the few states without a mandated health curriculum in the state's public school system.

The committee discussed its goal of leading the implementation of comprehensive school health education (CSHE) in Kentucky, and explored options as to how to reach the stated goal. Discussion ensued regarding whether to pursue an attempt to enforce the present requirement by KERA that students in grades 4, 8, and 12 be tested for competency in health education. It was decided that this approach would have to be taken soon since the 1996 legislative session would convene on January 2. Some committee members agreed to contact their state legislator about the possibility of getting legislation introduced during the 1996 session and to arrange meetings with the chairs of the Senate and House Education Committees.

The committee concluded that support must be obtained from organizations such as the Cancer Society, Diabetes Association, Heart Association, etc, for corroboration that substantial savings can be garnered through health education and lifestyle changes. An oversight committee has been formed by the various groups, and your Chair serves as KMA's representative. It was agreed that the primary committee goal is to mandate testing on equal levels with other academic subjects.

At the second meeting of the committee, the following options for attaining the committee's goals were discussed:

1. Legislation
2. Work the Department of Education
3. Local doctors work with local schools.

After considerable discussion, it was decided that the committee would approach the Department of Education since the requirement for health education already exists in the Kentucky Education Reform Act (KERA). The committee directed the Chair to write to Commissioner Cody of the Department and request a meeting with him, committee members, legislators, and other civic organizations interested in implementation of health education in schools. The Division Director of Site-Based Councils, and Linda Onslaw of the Northern Kentucky Cancer Society, were also suggested for inclusion in the meeting.

The committee contacted the four physician legislators and requested that they write to Dr Cody expressing concern for health education. Articles have been developed for the *KMA Communicator*, and correspondence written to county medical societies asking KMA members to write regarding this issue.

At the third committee meeting, it was reported that the meeting with the Department of Education had been narrowed down to three dates. All physician legislators, as requested, had either called or written to Dr Cody, Education Commissioner, along with several health-related organizations that joined in with our efforts. Dr Cody was very impressed with the number of letters written and calls made.

The meeting with Dr Cody and Department of Education representatives was scheduled for May 22 at 3:00 PM. Attending with Dr Young were Greg Cooper, MD, and Rebecca Shadowen, MD. Attending from the Department of Education were Jean Cain, Core Content Developer, and Ed Reedy, who is in charge of KERA testing. Our goals are as follows: 1) to increase testing in health education in KERA testing; 2) to increase core content guidelines; and 3) to set up a division to support schools in implementing CSHE.



In order to get physicians interested in school health education at a local level, the Chair presented a handout to be used as an example of things to request of local physicians. This list was printed in the *Communicator* and *Journal*.

Significant improvements in the core content were made as a result of this meeting. Further communications with the State School Board have been initiated to address the weight of health testing on KERA. The August School Board meeting will address this issue.

On behalf of the committee, we wish to express our appreciation to the members of KMA for their trust and support. Our children are truly our legacy. We believe this committee's work and goals are in the highest interest of medicine, and with your continuing assistance, we are confident we will eventually prevail.

Thomas L. Young, MD
Chair

END OF CONSENT CALENDAR ITEMS

Report of the Committee on Community and Rural Health

The Community and Rural Health Committee met on one occasion this year to discuss various health and safety issues.

The committee previously reviewed the issue of disability insurance for medical students and residents. In follow-up to the discussion, the committee communicated with the deans of the U of L and U of K medical schools to determine the feasibility of the schools offering disability insurance to students and residents. After communicating with the schools, it was determined that the medical schools were making a more concerted effort to provide students and residents with options on receiving the insurance. With the various options, the committee received word from the student and resident members that they were able to pursue the insurance plans best suited to their individual needs.

Another issue that the committee discussed was the role of public health department services in the changing health delivery system. Rice C. Leach, MD, Commissioner, Department for Health Services, asked the Kentucky Medical Association for support of the public health system with regards to physician support and patient education. After much discussion, a motion was approved that the KMA recognize the fact that public health departments serve a vital function to the continued public health and the community, and that the Community and Rural Health Committee urge the KMA Board of Trustees to encourage physicians in the state to have discussions on the local level with their health departments and hospitals to help better define what the future role of health departments is in the Commonwealth as the medical climate changes.

Another major initiative under the auspices of the Community and Rural Health Committee is the work of the Subcommittee on Domestic Violence. The subcommittee met five times this year to develop a new physician policy and procedure manual for the identification and reporting of child abuse and spouse abuse in patients. The development of the medical protocol and policy resulted from meetings of the Legislative Task Force on Domestic Violence which convened throughout 1995. The task force recognized that physicians are an integral link in the medical community to identify, treat, and report patients who present with symptoms of abuse, and many victims of domestic abuse will go to a doctor for treatment, making the physician their first contact after the abuse has taken place.

The subcommittee was formed four years ago to raise physician awareness of the problems of domestic violence. Three years ago, the subcommittee developed a comprehensive educational packet with materials about child abuse, adult abuse, and elderly abuse and sent the packet to all licensed physicians practicing in Kentucky. In order to determine the impact that the educational packet had on physicians, the subcommittee undertook a survey of issues related to domestic violence.

The survey was sent to a representative sample of 500 physicians of various specialties in Kentucky and achieved a response rate of 46%. The KMA survey contained questions similar to a survey undertaken by the Jefferson County Medical Society (JCMS) in 1991-92. Several questions on

the KMA survey were written in a similar way to compare with responses from the 1992 JCMS survey. The major findings of the survey were as follows: 59% of respondents were aware that there was a state law that required medical professionals to report confirmed and/or suspected spouse abuse to appropriate authorities, compared to 29% in the 1992 JCMS survey; 47% of respondents had filed a spouse abuse report on behalf of a patient as compared to 24% in the 1992 JCMS survey. In addition, 59% of respondents indicated that a state law should require medical professionals to report spouse abuse. Finally, 76% of respondents indicated that more education is needed in Kentucky for physicians on issues related to identifying, reporting, and treating abuse in patients.

After receiving the results of the survey, the subcommittee recognized that an impact had been made regarding physician awareness of domestic violence issues and proceeded with the development of a new medical policy and protocol for physicians to document, interview, and report patients who are suspected of suffering from or have confirmed symptoms of domestic abuse. Once the new policy and protocol are formulated, the subcommittee will use the policy and protocol as a guideline to plan a three-hour education course for physicians to be offered at different sites across the Commonwealth. HB 309, passed by the 1996 General Assembly, mandates that all primary care physicians licensed in Kentucky attend a three-hour training course on domestic violence by 1999. Physicians must attend a course approved by the Cabinet for Human Resources and the Board of Medical Licensure. In response to the demand for this course, the subcommittee is planning to have a three-hour course available in the late fall which would meet the requirements of the Cabinet for Human Resources and Board of Medical Licensure.

The course would be composed of topics related to the new policy which includes proper documentation of signs of abuse, interviewing techniques, information on the various laws which physicians must follow in identifying and reporting, and a model protocol that physicians can use as a guideline when dealing with a patient suspected of suffering child abuse or spouse abuse.

The subcommittee will have another meeting before the Annual Meeting, probably in August, to finalize the policy and protocol, and upon completion will make the policy and protocol available to physicians in Kentucky.

Finally, the Chair of the Community and Rural Health Committee, Edmond A. Hooker, MD, stepped down in June, and his replacement will be Baretta R. Casey, MD, who has been a long-standing committee member and Chair of the Subcommittee on Domestic Violence. On behalf of the committee, much thanks go to Dr Hooker for a job well done.

The members of the Community and Rural Health Committee and the Subcommittee on Domestic Violence would like to thank the Board of Trustees for the ability to serve.

Baretta R. Casey, MD
Chair

RECOMMENDATIONS:

1. The Community and Rural Health Committee urges the KMA Board of Trustees to encourage physicians in the state to have discussions on the local level with their health departments and hospitals to help better define what the future role of health departments is in the Commonwealth as the medical climate changes.
2. The Subcommittee on Domestic Violence recommends that the domestic violence issues survey results be made known to all Kentucky physicians through the *Journal of the Kentucky Medical Association*.
3. The Subcommittee on Domestic Violence recommends a three-hour training course be developed for primary care physicians in Kentucky.

Recommendations, Reference Committee E:

Reference Committee E reviewed the Report of the Committee on Community and Rural Health and recommends that the report and its recommendations be adopted.

Report of the Statewide Health Information Network Feasibility Study Committee

The Statewide Health Information Network Feasibility Study Committee met on two occasions, January 31 and February 21.

The Committee was appointed to implement Resolution F, passed by the 1995 KMA House of Delegates which called for "KMA to begin studying and evaluating options for the development of a statewide health information network with a cost structure for participating physicians, and that these options be made available to the House of Delegates no later than the 1996 Annual Meeting."

HEALTH INFORMATION NETWORK (HIN) DEFINITION

While there is no universally agreed upon definition of a Health Information Network, the Committee used the following description from the literature as a reasonable model.

A Health Information Network (HIN) is an electronic network linking all health care participants. It provides the data, voice, and image network to support a given delivery system. HINs are typically established in a community, but efforts are underway to establish state and regional HINs, as well.

HINs enable organizations to exchange clinical, financial, and administrative information electronically with other designated organizations. The role of an HIN is to enhance the efficiency and delivery of health care by allowing the electronic exchange of information among health care entities. The information exchanged includes information typically transferred between organizations by paper, document, phone, or fax; and information that is currently transferred electronically, but by redundant, nonstandard networks and computer equipment.

There are no statewide Health Information Networks in operation today. Most activity in developing information networks is being done at a county or metropolitan area level because logistically it's easier to pull these groups together on a local basis. The technology does exist for networks to be developed at the state and regional levels. Efforts to build statewide networks are underway in Wisconsin and California.

OVERVIEW OF CURRENT ACTIVITY

There is considerable activity by medical organizations and others to communicate electronically via computer. The committee reviewed several that are in operation.

State Medical Association "Internet Gateways"

Florida Medical Association

The Florida Medical Association has established a service called MedONE. FMA members subscribe to the service which allows access to various physician data bases through access to the Internet, as well as access to information specific to the Florida Medical Association, such as legal updates; FMA publications; meeting dates with on-line registration; political action committee information; and board, council, committee, and membership information. County medical societies are tied into this network through a bulletin board system for distribution of information. The service also includes E-mail through the Internet, a directory of MedONE subscribers, and several on-line continuing medical education opportunities, as well as on-line discussion groups for physicians.

Florida charges a one-time fee to enroll and connect to the system and offers a choice of several subscription structures.

Michigan State Medical Society

Michigan Medical Society has a similar program which provides unlimited access to the Internet, access to clinical data bases, and E-mail to colleagues, legislators, and the Medical Society. It has a one-time set-up fee and a flat monthly fee. Oregon also has introduced services similar to those listed above.

Internet WEB Sites

Internet WEB sites are different than the Internet gateways described above. In an Internet gateway, the sponsoring organization, in this case the medical society, furnishes access to the Internet, and as a part of that, those who subscribe to the service have access to information made available by the medical society. To access a WEB site, one must already have access to the Internet/Worldwide WEB, and anyone having that access can access the information contained on the WEB site. Thus, anyone, society members

or members of the general public at large, can access the information on a WEB site.

AMA (<http://www.ama-assn.org>)

The AMA established a WEB site late in 1995. Individuals accessing the site can look at the latest *American Medical News* articles, *JAMA* articles, and other public education oriented material. There is access to the directory of AMA officers and staff, and state, county, and national specialty societies. There is also a location for students to access various information sources from the AMA. There are hyper links to numerous other medically-related organizations. The site is accessed 40,000 times per week. The page provides access to the AMA by physicians as well as the general public.

Virginia (<http://www.msv.org>)

Virginia has set up a WEB site where anyone can obtain the names of officers, council members, committee members, and senior staff members; access various Virginia Medical Society policies; and get information on legislation.

New Hampshire (<http://www.mednexns.com/nhms/>)

New Hampshire Medical Society has a WEB site similar to that developed by Virginia, with essentially the same services. Other states with associations with WEB sites are Delaware, Louisiana, Massachusetts, Missouri, Texas, Utah, with more coming on line each month.

In all of the above, the end user pays no fee to access the information on the WEB sites. The sponsoring entities pay that cost which varies depending on the sophistication of the technology used to make the information available and the entities chosen by the sponsor to develop and help maintain the site.

Health Information Networks

Health Information Networks are the entities that this committee was asked to discuss. Examples of some of the activities now underway include:

California

The California Health Information Network is being developed through a 34-member coalition of California's largest providers, payors, employers, and health organizations, including the California Medical Association, Kaiser Permanente, the Hospital Council of Northern and Central California, Aetna, Prudential, and Blue Cross/Blue Shield. As designed, it will provide community health information networks and other customers with technical standards, communication channels, technological expertise, and contract pricing. Services initially available are claims and encounter submission (physician and hospital), claims status, eligibility, remittance advice, and referrals). Insurers and other payors pay for the electronic claims and encounters submitted to them. Providers and others pay for whatever transactions they initiate, such as claims status and eligibility requests. The network plans to offer clinical applications, starting with simple services such as electronic mail for clinicians. Later, services covering pharmaceutical and lab information may be introduced. The group plans to eventually have a master patient index and/or data repository of clinical information.

The consortium, which is a non-profit corporation called Health Care Data Information Corporation, has an initial operating budget of about \$500,000, which is financed partially through dues from the member organizations and by sponsoring vendors.

Wisconsin

The Wisconsin Health Information Network is a joint venture between Aurora and Ameritech. Ameritech is a large regional phone company. Aurora is a religious order from Aurora, Illinois, which operates hospitals. Aurora and Ameritech provided all the funding for the Wisconsin Health Information Network which currently operates in the eastern part of Wisconsin and has a market base in that area of about one-half of the physicians in the state. The Wisconsin Medical Association has signed an endorsement agreement with WHIN allowing it to use the Association's logo, name, and endorsement statement in all of its marketing activities. The state Association had no part in the development of the network and has no financial investment. Sources in Wisconsin indicated that there was a tremendous amount of technology and ongoing marketing and administrative cost associated with this venture and that the network to date had not met some of the goals that the developers had originally set. There are also some concerns about data and medical records confidentiality and that apparently is keeping some physicians from joining the network.



The Wisconsin network, owned by the Aurora/Ameritech joint venture, established a subsidiary called Health Network Ventures which is a franchise network which sells the software and all updates and support for the administration of networks to interested parties.

Iowa (legislated)

In 1994, the Iowa legislature approved creation of a Community Health Management Information System or CHIMIS. The CHIMIS is a statewide computerized network which will be implemented in three phases. The first phase, which is scheduled for implementation July 1, 1996, will involve computer transmission of insurance claims using a uniform claims format. It is anticipated that paperless claims will be easier, cheaper, and faster than processing paper claims. Physicians will be able to verify rapidly patients' insurance eligibility and coverage levels. After July 1, 1996, all physicians must submit claims electronically.

The second phase is to be implemented July 1, 1999 and will expand on information collected from physicians. In addition to data from the HCFA 1500 and UB-92 claim forms, data may be collected from x-ray and pathology reports, patient assessments/satisfaction surveys, clinical data sets, and results of cooperative studies.

The third phase has not been determined, but will involve implementation of patient specific electronic records.

The system was initiated when, after a series of studies, the Iowa General Assembly passed legislation to establish an integrated electronic health management information system for the state of Iowa. Funding for the development of this project so far has come from the John A. Hartford Foundation. Future funding sources are not clear. The Iowa Medical Association is working closely with state government and others in the development of the network and there are a number of advisory committees that have been established to address issues such as confidentiality of medical records, the appropriate use of the data gathered through the repository, etc.

Kentucky

There are currently three entities with network capability which are either operational or plan to become operational in Kentucky. Two shared their plans with the committee.

Thorobred Health Information System

The Thorobred Health Information System is owned by The Physicians Inc, an affiliation of over 1000 physicians in the Jefferson County area. The main focus of the group is on member credentialing, quality and outcomes studies and reports, development of clinical guidelines, practice development, and automation which allows communication and consultation among health professionals and facilities throughout the community.

We were pleased to have a number of representatives from TPI and Health Ventures Networks, TPI's software vendor, meet with us on January 31. James L. Bersot, Jr, MD, President and CEO of TPI, gave an in-depth presentation to the Committee regarding the current system and plans for future expansion. TPI's vision is to increase electronic communication between physicians for obtaining patient information, making referrals, and exchanging data with hospitals; allowing physicians to better communicate with insurers, to obtain preauthorization, and to submit electronic claims; and to better enable physicians to communicate with pharmacies, laboratories, employers, and other related entities. Dr Bersot pointed out a number of the potential benefits for patients which included quick and easy transfer of patient information between various providers, decreases in time to obtain patient data, reduction of duplicative orders and testing, as well as reductions in patient wait time.

The benefits for physicians are 24-hour access to hospital/patient data by participating physicians without hospital staff interaction; a mechanism is provided to follow a patient through the continuum of care; on-line real time inquiries to insure protocols, claims, and referrals increase responsiveness; and it is felt that electronic claims submission will improve cash flow and reduce bad debt. Similar advantages were presented for hospitals and pharmacies.

While some observers have indicated concern regarding the security of patient records in a health information network, the Thorobred System places great emphasis on system security and confidentiality of records. Each user is supplied with a unique ID and password, and each user access is verified against the unique memory identification specific to the individual personal computer. Information is transmitted through dedicated private

lease communication lines and access is limited to suppliers and to Thorobred. All information is scrambled while communicating with Thorobred and the system has the capability of tracking user access through system logs, as well as limiting a user's PC from saving or printing information.

Dr Bersot spent considerable time answering questions from the committee and the committee was very appreciative for the obvious effort and preparation TPI undertook in conjunction with our meeting.

IMS Medacom

IMS (Integrated Medical Systems, Inc) Medacom was founded in Colorado in 1985. Its mission is to develop computerized medical communication networks for use by health care providers throughout the United States. Currently, there are 36 networks in existence around the country. Medacom literature indicates that it has 750 physicians on-line in the Louisville and Lexington areas. It is designed to link physicians, hospitals, reference laboratories and others electronically, utilizing a wide variety of computer technology. The services provided in Kentucky include eligibility inquiry and benefit verification, reporting lab results, referral authorization requests, all-payer claims, claims status with specific payors, E-mail, and other electronic functions.

Medacom representatives provided an in-depth presentation on the services it currently provides, as well as those planned for the future. During the meeting, we learned that IMS Medacom has been purchased by the Eli Lilly Company and representatives shared some of the plans and new products being rolled out to increase the efficiency of the prescription process through electronic data interchange.

Some of the benefits identified for Medacom network users include improved efficiency of ancillary departments, such as admitting and medical records, through reduced telephone inquiries and responses; improved quality of care through faster reporting of test results and initiation of therapy; reduced cost of duplicated tests; easier compliance with managed care contract protocols and procedures; and faster medical record completion and filing of bills, and reduced account receivables through electronic signature. The committee appreciated the information IMS Medacom shared with it.

After considerable discussion, the committee came to the following conclusions. For KMA to coordinate or initiate a statewide health information network, a considerable amount of resources would be required. There is significant start-up cost involved in both staffing and equipment, and the committee feels it would be extremely difficult to raise enough capital voluntarily to maintain such a project during its start-up phase.

While the programs that were presented to the group appear to be well thought out, have good vendor support, and are offered by reasonably financed and reputable organizations, much of their appeal is based on the services that may be available in the future, but are not currently offered. There is hesitation on the part of many physicians to purchase the hardware and software necessary to participate in a health information network because of the lack of standardized formats for electronic communication between systems or a standardized format in the way information is submitted to carriers for payment. While there are activities underway currently to address this issue, many problems of compatibility and standardization are still unresolved.

The committee was also concerned with the confidentiality of medical records. While some of the security measures described seem reasonable, these types of programs are not in wide enough use to have had any meaningful experience in terms of security breaches.

The committee did feel it reasonable for KMA to encourage its members to become familiar with electronic data interchange and to remain aware of the advances being made in technology which will one day bring these types of projects into reality. The committee feels it would be appropriate for KMA to continue to monitor future developments not only in state health information networks, but in other medically-related communications technology as well, and keep the membership advised as appropriate. As a result, the committee makes the following recommendations:

1. KMA should encourage its members to become familiar with electronic data interchange and to help them remain aware of ongoing technological advances.
2. KMA should not attempt to initiate the development of a Statewide Health Information Network. It is appropriate for KMA to continue to monitor

future developments in efforts to increase efficiency and decrease costs through the use of electronic data interchange and keep the membership advised as appropriate.

3. KMA should serve as a forum where information on emerging technology and services could be presented by developers and shared with the membership, as appropriate.
4. Because our committee was appointed with the charge of making recommendations on the current feasibility of initiating a statewide health information network, the committee suggests that the Board consider referring these recommendations to a standing committee of the Association for implementation.

The committee appreciates the tremendous effort made by both The Physicians Inc and IMS Medacom to bring us information, not only on their products, but on the advances being made in electronic communications as a whole. As Chair, I also want to extend my appreciation to the members of the committee who brought not only their knowledge on this issue, but willingness to absorb a tremendous amount of information and share their thoughts with the entire membership.

Donald J. Swikert, MD
Chair

RECOMMENDATIONS:

1. KMA should encourage its members to become familiar with electronic data interchange and to help them remain aware of ongoing technological advances.
2. KMA should not attempt to initiate the development of a Statewide Health Information Network. It is appropriate for KMA to continue to monitor future developments in efforts to increase efficiency and decrease costs through the use of electronic data interchange and keep the membership advised as appropriate.
3. KMA should serve as a forum where information on emerging technology and services could be presented by developers and shared with the membership, as appropriate.
4. Because our committee was appointed with the charge of making recommendations on the current feasibility of initiating a statewide health information network, the committee suggests that the Board consider referring these recommendations to a standing committee of the Association for implementation.

Recommendations, Reference Committee E:

Reference Committee E reviewed the Report of the Statewide Health Information Network Feasibility Study Committee and recommends that the report and its recommendations be adopted.

RESOLUTION 96-113

HIV Testing

Jefferson County Medical Society

WHEREAS, perinatal transmission of the human immunodeficiency virus (HIV) accounts for the majority of HIV infections among children; and

WHEREAS, maternal treatment with zidovudine during pregnancy has been shown to reduce the perinatal transmission rate of HIV from 25.5% to 8.3%; now, therefore, be it

RESOLVED, that the Kentucky Medical Association recommend HIV testing of all pregnant women.

Recommendations, Reference Committee E:

Reference Committee E reviewed Resolution 113, HIV Testing, introduced by the Jefferson County Medical Society, and recommends that the Resolved be amended by additional wording. The amended Resolved would then read:

RESOLVED, that the Kentucky Medical Association recommend HIV testing of all pregnant women and communicate this same recommendation to all providers of prenatal and obstetrical care.

The Reference Committee recommends that Resolution 113 be adopted as amended.

Magdalene Karon, MD, Lexington, recommended revising the amended Resolved by adding the words "and payors" after "providers." The Resolved would then read:

RESOLVED, that the Kentucky Medical Association recommend HIV testing of all pregnant women and communicate this same recommendation to all providers and payors of prenatal and obstetrical care.

A motion was made, seconded, and carried to adopt this revision. Resolution 113 was then adopted as amended from the floor.

Resolution 113, adopted as amended by the House, would read:

RESOLUTION 96-113

HIV Testing

Jefferson County Medical Society

WHEREAS, perinatal transmission of the human immunodeficiency virus (HIV) accounts for the majority of HIV infections among children; and

WHEREAS, maternal treatment with zidovudine during pregnancy has been shown to reduce the perinatal transmission rate of HIV from 25.5% to 8.3%; now, therefore, be it

RESOLVED, that the Kentucky Medical Association recommend HIV testing of all pregnant women and communicate this same recommendation to all providers and payors of prenatal and obstetrical care.

RESOLUTION 96-116

Partners for Family Farms

Estill County Medical Society

WHEREAS, in 1993 the Burley Tobacco Growers Cooperative Association established a pilot program, the Kentucky Organic Growers, which directly connected consumer families with farm families by providing good food through employing sustainable agricultural practices; and

WHEREAS, in 1994 the Kentucky Medical Association and the Kentucky Academy of Family Physicians adopted a resolution regarding their support for these efforts of the Burley Tobacco Growers Association; and

WHEREAS, the Burley Tobacco Growers Cooperative Association has expanded the efforts of the Kentucky Organic Growers to include opportunities for Kentucky's farmers to provide good, healthful food for Kentucky's families through the Commodity Growers Cooperative Association; and

WHEREAS, in 1996 the Burley Tobacco Growers Cooperative and the Commodity Growers Cooperative established the Partners for Family Farms to: provide additional methods for educating urban consumers on the benefits of locally grown food; educate urban leaders about the opportunities for community revitalization through markets which make available wholesome local farm products to urban consumers; and to train economic development agencies/organizations about the opportunities for increased jobs, economic security, and community vitality through community-supported, value-added businesses, as well as direct markets for local farm products; and

WHEREAS, the medical community of Kentucky sees these efforts as vital to the health of Kentucky families and Kentucky's communities, both urban and rural; now, therefore, be it

RESOLVED, that the Kentucky Medical Association continue to show support for the Commodity Growers Cooperative Association and its new affiliate organization, the Partners for Family Farms, by:

- Intensifying education efforts directed at patients and the community-at-large, consistent with the principles set out in this resolution, emphasizing the connection between sustainable agriculture and health; and
- Working with agricultural leadership, including the Burley Tobacco Growers Cooperative Association, in efforts to influence governmental policies which encourage local food production and allow good, healthful food to be available to all; and
- Helping establish mechanisms to increase the purchase of locally grown food by health institutions, including hospitals, universities, and health-affiliated governmental institutions; and
- Encouraging the public, through local consumption habits to support sustainable agricultural traditions of local food production; and
- Working with the Commodity Growers Cooperative and the Partners for Family Farms in their efforts to fund the expansion of marketing opportunities for Kentucky farmers.

Recommendations, Reference Committee E:

Reference Committee E reviewed Resolution 116, Partners for Family Farms, introduced by the Estill County Medical Society, and recommends the dele-



tion of all language in the Resolved following the words "Partners in Family Farms" and substitution of additional wording so that the Resolved would read as follows:

RESOLVED, that the Kentucky Medical Association continue to show support for the Commodity Growers Cooperative Association and its new affiliate organization, the Partners for Family Farms and work with CGCA as a partner for Family Farms by formally appointing a liaison physician to assist CGCA in its educational and marketing objectives.

Reference Committee E recommends that Resolution 116 be adopted as amended.

Paul Craig, MD, Ashland, noted concern because this program is a subsidiary of the tobacco growers and he did not feel KMA should associate itself with tobacco. He was particularly concerned that a KMA endorsement might be used in advertising, and recommended rejection of the resolution.

Barbara Phillips, MD, Lexington, spoke in support of the resolution. She noted that a similar resolution had been adopted last year, and pointed out that this program was designed to help farmers diversify.

John Patters, MD, Estill County, spoke as the author of the bill. He is on the Advisory Board of the Commodity Growers Cooperative and the Partners for Family Farms. He noted that the intent was for KMA physicians to work with this group to help achieve the Association's public health objectives.

Gilroy Daley, MD, Hazard, also spoke in support of the resolution.

Greg Cooper, MD, Cynthiana, also spoke in favor of the intent of the resolution.

Barbara Phillips, MD, Lexington, then moved for deletion of the new wording suggested by the reference committee, so that the Resolved would end with the words "the Partners in Family Farms." The Resolved would then read as follows:

RESOLVED, that the Kentucky Medical Association continue to show support for the Commodity Growers Cooperative Association and its new affiliate organization, the Partners for Family Farms and work with CGCA as a partner for Family Farms by formally appointing a liaison physician to assist CGCA in its educational and marketing objectives.

The motion was seconded and carried.

Harry W. Carlross, MD, reported that the Board of Trustees was also in favor of this motion because it is KMA policy not to appoint an official physician liaison to nonmedical groups due to insufficient resources and personnel.

A motion was then made, seconded, and carried to adopt the Resolution 116 as amended from the floor of the House.

Resolution 116, adopted as amended by the House, would read:

RESOLUTION 96-116

Partners for Family Farms Estill County Medical Society

WHEREAS, in 1993 the Burley Tobacco Growers Cooperative Association established a pilot program, the Kentucky Organic Growers, which directly connected consumer families with farm families by providing good food through employing sustainable agricultural practices; and

WHEREAS, in 1994 the Kentucky Medical Association and the Kentucky Academy of Family Physicians adopted a resolution regarding their support for these efforts of the Burley Tobacco Growers Association; and

WHEREAS, the Burley Tobacco Growers Cooperative Association has expanded the efforts of the Kentucky Organic Growers to include opportunities for Kentucky's farmers to provide good, healthful food for Kentucky's families through the Commodity Growers Cooperative Association; and

WHEREAS, in 1996 the Burley Tobacco Growers Cooperative and the Commodity Growers Cooperative established the Partners for Family Farms to: provide additional methods for educating urban consumers on the benefits of locally grown food; educate urban leaders about the opportunities for community revitalization through markets which make available wholesome local farm products to urban consumers; and to train economic development agencies/organizations about the opportunities for increased jobs, economic security, and community vitality through community-supported, value-added businesses, as well as direct markets for local farm products; and

WHEREAS, the medical community of Kentucky sees these efforts as

vital to the health of Kentucky families and Kentucky's communities, both urban and rural; now, therefore, be it

RESOLVED, that the Kentucky Medical Association continue to show support for the Commodity Growers Cooperative Association and its new affiliate organization, the Partners for Family Farms.

RESOLUTION 96-117

AMA-CPT Coding Northern Kentucky Medical Society

WHEREAS, the American Medical Association Current Procedural Terminology (AMA-CPT) is the accepted standard for correct coding of physician services; and

WHEREAS, medical insurance carriers currently all use the AMA-CPT coding system for claims processing and physician payment; and

WHEREAS, private software companies have developed health insurance claims editing software that uses the CPT coding system and promote their products as based on CPT rules and guidelines; and

WHEREAS, the medical community and insurance industry recognize the benefits of proper claims-editing software to detect improper coding of claims and prevent erroneous payment; and

WHEREAS, proper coding for multiple separate and unrelated services may require separate procedure codes and modifiers, and such proper coding with separate codes and modifiers does not represent unbundling of service; and

WHEREAS, some insurance carriers processing claims of Kentucky physicians have implemented claims-editing software that ignores essential AMA-CPT coding rules, or also ignores accepted RBRVS standards in claims processing, resulting in inappropriate bundling of separate services and inappropriate denial of payment for legitimate services; and

WHEREAS, such insurance carriers using inappropriate bundling software edits gain an unfair competitive advantage over those other insurance companies who adhere to CPT or RBRVS coding and payment principles; and

WHEREAS, such inappropriate bundling software edits compromise the quality of care of our patients, interfere in the patient-physician relationship, greatly increase administrative expenses, and abuse physicians by disallowing reimbursement for some necessary services if provided on the same date as other necessary services; and

WHEREAS, current Kentucky Medicaid claims processing using ClaimCheck software inappropriately rebundles separate physician services and, in doing so, exceeds the intent of KRS 205.6318, paragraph (2), which states "Utilize...computer software to detect the unbundling of claims..."; and

WHEREAS, the interests of patients, physicians, and health insurance carriers are best served when claims processing follows the same accepted standards of AMA-CPT coding and/or RBRVS rules; now, therefore, be it

RESOLVED, that the Kentucky Medical Association endorse AMA-CPT as the standard accepted coding system in Kentucky and that proper use of CPT by insurance carriers requires adherence to all of its rules and guidelines; and be it further

RESOLVED, that the Kentucky Medical Association recommend that the Insurance Commissioner and the Kentucky Legislature require Medicaid and private health insurance carriers processing claims from Kentucky physicians to adhere to all CPT rules and guidelines, including code modifiers; and be it further

RESOLVED, that the Kentucky Medical Association request the Department of Medicaid Services to make the necessary revisions of the inappropriate bundling edits in the ClaimCheck software which erroneously process Medicaid claims from physicians and disallow legitimate claims for services.

Recommendations, Reference Committee E:

Reference Committee E recommends that Resolution 117 be adopted.

RESOLUTION 96-121

HCFA-1500 Form Fayette County Medical Society

WHEREAS, the HCFA-1500 form has been determined to be the standard form for submission of medical charges to all major insurance carriers, including Medicare and Medicaid; and

WHEREAS, the HCFA-1500 form has been jointly developed by third-party carriers, HCFA, and the AMA; and

WHEREAS, the HCFA-1500 form revisions are considered only after a significant change in the need to obtain patient service data in an organized manner from all providers throughout the country; and

WHEREAS, all major insurance carriers have agreed to require that health care providers uniformly use the HCFA-1500 form to standardize the process of claims submission; and

WHEREAS, there exists a need to facilitate a clear and uniform understanding of the EOB (explanation of benefits) as well as prompt processing of patient service claims by providers, thereby increasing office productivity; now, therefore, be it

RESOLVED, that the Kentucky Medical Association ask the American Medical Association to seek a requirement for all insurance carriers to standardize the requirements for claim submission; and be it further

RESOLVED, that KMA ask the AMA to seek a requirement that all insurance carriers develop and adhere to a standardized format of an EOB (explanation of benefits) sent to providers and subscribers.

Recommendations, Reference Committee E:

Reference Committee E recommends that Resolution 121 not be adopted. Although it is a meritorious resolution that we feel almost all physicians would support, we are informed that it has been previously adopted and is redundant.

The Board of Trustees pointed out that this was reaffirmation of AMA policy, and recommended it be referred to the KMA Board for further consideration. A motion was made, seconded, and carried to refer Resolution 121 to the Board of Trustees.

RESOLUTION 96-122

Kentucky Lawsuit Against FDA Regulations Fayette County Medical Society

WHEREAS, tobacco-related diseases are some of the major causes of morbidity and mortality in the Commonwealth of Kentucky; and

WHEREAS, 85% of chronic tobacco users acquire the addiction before age 18; and

WHEREAS, the FDA regulations regarding tobacco are directed to lessen the rate of teenage smoking; and

WHEREAS, the KMA has previously expressed its support for FDA regulations; now, therefore, be it

RESOLVED, that the KMA express to appropriate state officials that we do not support the use of tax dollars to finance efforts, including lawsuits, that are aimed at overturning or postponing the FDA regulations regarding tobacco.

Recommendations, Reference Committee E:

Reference Committee E recommends that Resolution 122 be adopted.

RESOLUTION 96-126

Primary Care Physicians' Treatment of Depression Nancy Swikert, MD, President, KAFP

WHEREAS, Blue Cross/Blue Shield has recently stopped reimbursing primary care physicians for the outpatient treatment of depression and other mental health diagnoses; and

WHEREAS, this places a tremendous hardship on rural patients and physicians because of the shortage of psychiatrists in rural areas; and

WHEREAS, primary care physicians have appropriate training and knowledge to care for most patients diagnosed with outpatient depression and other mental health diagnoses; now, therefore, be it

RESOLVED, that the Kentucky Medical Association opposes the reimbursement policy of Blue Cross/Blue Shield or any other insurer not paying primary care physicians for the outpatient treatment of depression and other mental health diagnoses; and be it further

RESOLVED, that KMA communicate this policy to the various insurers in Kentucky; and be it further

RESOLVED, that KMA communicate this concern to the Commissioner of Insurance.

Recommendations, Reference Committee E:

Reference Committee E recommends that Resolution 126 be adopted.

Mr Speaker, Reference Committee E recommends the adoption of the report of Reference Committee E as a whole, as amended.

Mr Speaker, I would like to thank the other members of this committee — Robert J. Emslie, MD, Bowling Green; Robert L. Baker, Jr, MD, Crescent Springs; Nicholas R. Jurich, MD, Prestonsburg; Michael T. Macfarlane, MD, Louisville; John A. Patterson, MD, Irvine; and John R. White, MD, Lexington — for their time and thoughtful consideration of the issues referred to the reference committee. The Chair would also like to thank Ms Jean Wayne for her assistance in the preparation of this report.

Respectfully submitted,

REFERENCE COMMITTEE E

Robert J. Emslie, MD, Bowling Green, Chair
Robert L. Baker, Jr, MD, Crescent Springs
Nicholas R. Jurich, MD, Prestonsburg
Michael T. Macfarlane, MD, Louisville
John A. Patterson, MD, Irvine
John R. White, MD, Lexington

Harry W. Carloss, MD, Chair, Board of Trustees, made a motion on behalf of the Board that Gerald D. Temes, MD, of Louisville, be elected to a four-year term on the Judicial Council. Dr Temes was appointed by acclamation.

Election of Officers

Susan G. Bornstein, MD, Chair of the Nominating Committee, presented the slate of nominees for offices as follows:

| | |
|-----------------|----------------------------------------|
| President-Elect | C. Kenneth Peters, MD Jeffersontown |
|-----------------|----------------------------------------|

Dr Peters was elected by acclamation, and was escorted to the podium by Past Presidents Bob M. DeWeese, MD, and Robert R. Goodin, MD. KMA and AMA Past President Hoyt D. Gardner escorted Mrs Peters to the podium. The following nominees were also elected by acclamation:

| | |
|---------------------------------------------------------------------------------------------------------|----------------------------------------|
| Vice President | Donald R. Stephens, MD Cynthiana |
| Speaker, House of Delegates (To fill unexpired term of Dr Peters who was elected President-Elect) | John W. McClellan, Jr, MD Henderson |

Dr Bornstein then presented the slate of nominees for the office of Vice Speaker, House of Delegates:

| | |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|
| Vice Speaker, House of Delegates (To fill unexpired term of Dr McClellan, who was elected as Speaker) | Donald J. Swikert, MD Florence Thomas K. Slabaugh, MD Lexington |
|----------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------|

Delegates voted by ballot, resulting in the election of Thomas K. Slabaugh, MD, as Vice Speaker.

Dr Bornstein then presented the remainder of the slate of nominees, and each was elected by acclamation.

| | |
|----------------------------------------------------|-----------------------------------------|
| Secretary-Treasurer | William P. VonderHaar, MD Louisville |
| Delegate to the AMA (1/1/97-12/31/98) | Donald J. Swikert, MD Florence |
| Delegate to the AMA (1/1/97-12/31/98) | Robert R. Goodin, MD Louisville |
| Delegate to the AMA (1/1/97-12/31/98) | Wally O. Montgomery, MD Paducah |
| Alternate Delegate to the AMA (1/1/97-12/31/98) | William B. Monnig, MD Erlanger |



Alternate Delegate to the AMA
(1/1/97-12/31/98)

Alternate Delegate to the AMA
(1/1/97-12/31/98)

Bob M. DeWeese, MD
Louisville

Preston P. Nunnelley, MD
Lexington

Dr Bornstein then submitted the following nominations for the offices of Trustees and Alternate Trustees on behalf of the Trustee District nominating committees, and each was elected by acclamation:

| | |
|-------------------------|-----------------------------------------|
| 5th District Trustee | Daniel W. Varga, MD Louisville |
| 5th District Alternate | Susan M. Berberich, MD Louisville |
| 6th District Trustee | John T. Burch, II, MD Bowling Green |
| 6th District Alternate | James M. Pulliam, MD Franklin |
| 8th District Trustee | Thomas E. Bunnell, MD Erlanger |
| 8th District Alternate | James P. Farrell, MD Crestview Hills |
| 11th District Trustee | Richard A. Stone, MD Richmond |
| 11th District Alternate | Suvas G. Desai, MD Richmond |
| 15th District Trustee | Meredith J. Evans, MD Middlesboro |
| 15th District Alternate | David W. Douglas, MD London |

Election of 1997 Nominating Committee

The following physicians were elected by the House of Delegates to serve as the 1997 KMA Nominating Committee:

P. Bruce Barton, MD, Corbin, Chair
John W. Collins, MD, Lexington
Kathleen C. Harter, MD, Louisville
Rebecca D. Shadowen, MD, Bowling Green
David J. Zoeller, MD, Elizabethtown

Tellers Charles T. Watson, MD, Ashland; Harold D. Haller, MD, Louisville; and John W. Collins, MD, Lexington; were thanked for their efforts.

Preston P. Nunnelley, MD, Chair of the KMA Public Education Committee, showed a video relating to the committee's activities, including a very successful joint effort with the KMA Alliance to supply Kentucky elementary school teachers with the *I Can Choose* coloring book. Dr Nunnelley noted that KMA had received the AAMSE "Pinnacle of Success" Award for its publication, *MediScope*.

Richard F. Hench, MD, Lexington, Chair of the Kentucky Medical Insurance Company Board of Directors, presented an update on Kentucky Medical's status and activities, including slides showing insurance coverage being offered in various states by KMIC and its parent company in Michigan. Mr Steven L. Salman, who has announced his resignation as President and CEO of KMIC to accept the presidency of another physician-owned company, also made some brief remarks.

Dr VonderHaar reminded new members of the Board of Trustees that the next meeting of the Board was scheduled for Sunday morning at 7:30.

Newly installed KMA President William H. Mitchell, MD, next addressed the House. Dr Mitchell stressed the need for patient advocacy and consumer protection in managed care. He noted that all physicians need to understand the concept of PPOs.

Speaker Peters adjourned the 1996 Session of the KMA House of Delegates at 9:30 PM.

1996-97 KMA Committees

PHYSICIAN ADVISORY COMMITTEE TO HEALTH KENTUCKY

Russell L. Travis, MD, Lexington, Chair
Donald C. Barton, MD, Corbin
Harry W. Carloss, MD, Paducah
Salem M. George, MD, Lebanon
Ardis D. Hoven, MD, Lexington

SCIENTIFIC PROGRAM

James L. Borders, MD, Lexington, Chair
William H. Mitchell, MD, Richmond
J. Greg Cooper, MD, Cynthiana
Lourdes Corman, MD, Louisville
Salem George, Jr, MD, Louisville
Tamara James, MD, Lexington
Daniel E. Kenady, MD, Lexington
Paul McLaughlin, MD, Lexington (resident)
Michael Chua, Louisville (student)

SCIENTIFIC EXHIBITS

Richard A. Kieler, MD, Lexington, Chair
James P. Moss, MD, Louisville
Sibu Saha, MD, Lexington

CONTINUING MEDICAL EDUCATION

Thomas K. Slabaugh, MD, Lexington, Chair
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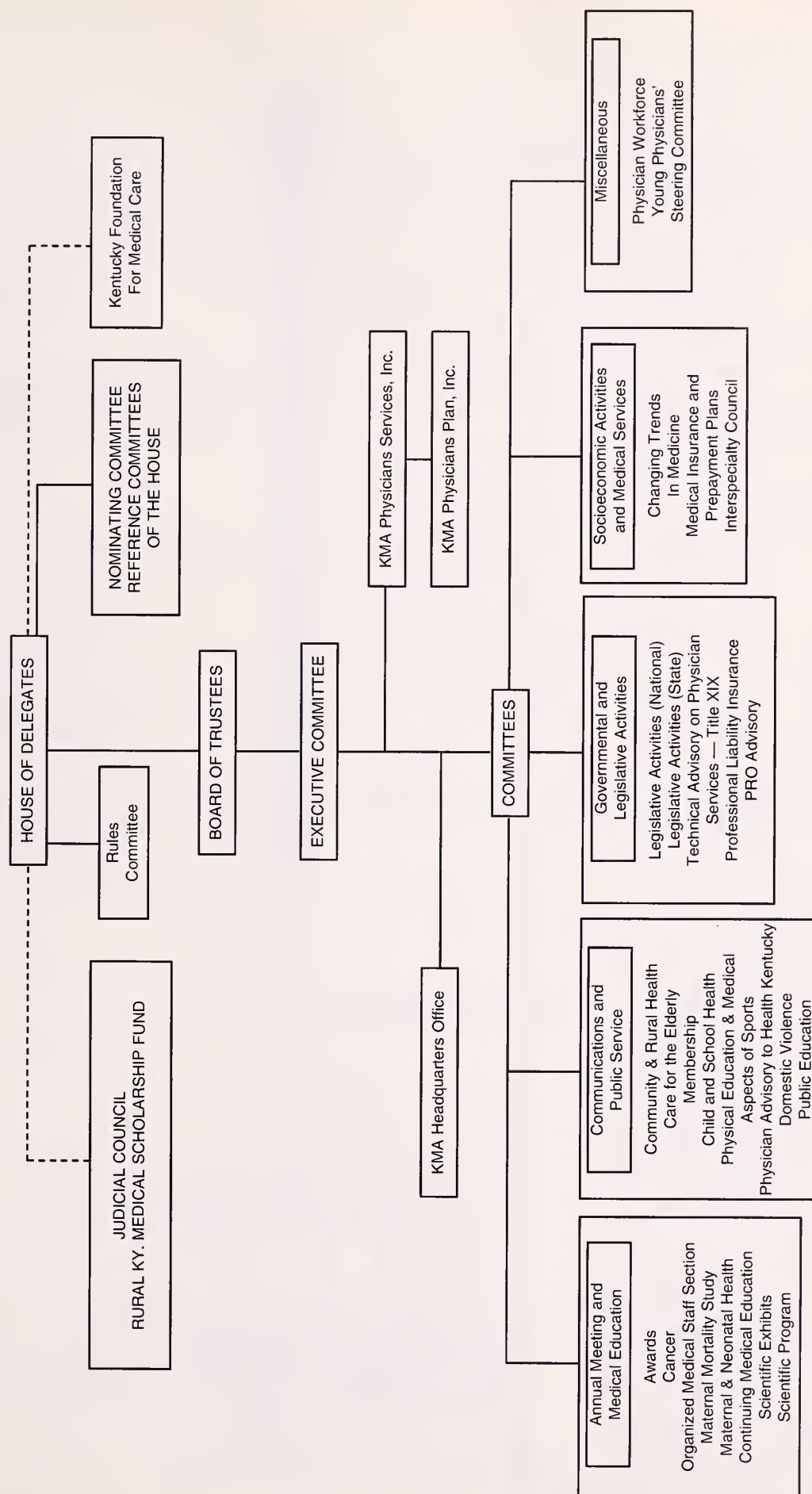
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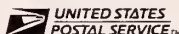
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Cumulative
Index
The Journal
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Volume 94 — 1996

| Month | Pages |
|-----------------|------------|
| January | 1 to 40 |
| February | 41 to 84 |
| March | 85 to 128 |
| April | 129 to 172 |
| May | 173 to 212 |
| June | 213 to 256 |
| July | 257 to 302 |
| August | 303 to 374 |
| September | 375 to 418 |
| October | 419 to 470 |
| November | 471 to 514 |
| December | 515 to 609 |

Edited by A. Evan Overstreet, MD
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SCIENTIFIC ARTICLES

A

Allergic Child, Recognizing the, 278
Angina, Transmyocardial Revascularization for Intractable, 432
Angiographic Localization of Small Bowel Bleeding Site with Methylene Blue Injection, Presurgical, 192
Asthma — Fact or Fancy, Ovarian, 96

C

Coccidioidomycosis in Kentucky, Pulmonary, 490
Communication Disorders in Children (Grand Rounds), Identifying, 197
Cryosurgery (Grand Rounds), Liver, 222

E

ECG Intervals in Acute Bipolar and Schizophrenic Relapse, 526
Enderectomy in a Community Hospital, Carotid, 314

F

Fibrosis in a Zinc Miner, Progressive Massive, 144

H

Head and Neck Masses (Grand Rounds), Practical Steps in the Management of Adult, 50

L

Laparoscopy in the Treatment of Acute and Chronic Right Lower Quadrant Pain, Use of, 16
Legionellosis, Hot Tub, 393

M

Myxoma — A Comprehensive Review of Reported Cases, Familial Cardiac, 96

N

Nipple Discharge, The Clinical Challenge of, 387

P

Pancoast's Syndrome Secondary to Thoracic Actinomycosis, 500
Pneumothorax in the Patient with AIDS, Treatment of, 59
Polymerase Chain Reaction: A Revolutionary New Procedure for the Laboratory Diagnosis of Infectious Disease, The, 148

R

Revascularization for Limb Salvage, Ten Year Experience With Infrainguinal, 270

S

Seizure Durations, ECT-Induced, 233

T

Thoracic Outlet Syndrome, Diaphragmatic Paralysis Following Scaleneotomy for, 13
Trigger Finger: Not Always Work Related, 498

SCIENTIFIC AUTHORS

A

Ahkee, Sunket, MD, 393, 500
Ahmad, Fazal, MD, 16

B

Baker, Mary, RN, MSN/MHA, 314
Becker, Carolyn E, MD, 59
Bland, Lauren E, PhD, 197
Bradford, William R, MD, 192

Buck, George E, PhD, 148
Bumpous, Jeffrey M, MD, 50

C

Clark, JD, MD, 105

D

Dillon, Marcus L, MD, 490

E

Earle, Gary F, MD, 314
Edwards, Michael J, MD, 222
El-Mallakh, Rif S, MD, 526

F

Flynn, Michael B, MD, 50

G

George, Salem M, Jr, MD, 270
Gotthardt, Martin, MD, 105

H

Haas, Scott, MD, 233
Heine, Michael, MD, 13

J

Jones, Erwin A, Jr, MD, 278
Joyce, Betty W, MD, 144

K

Kasdan, Ann S, RN, 498
Kasdan, Morton L, MD, 498
Klamer, Thomas W, MD, 270

L

Lambert, Glenn E, MD, 270
Lansing, Allan M, MD, PhD, 96, 432

Lash, Joseph A, MD, 432
Leis, Valerie M, 498
Lewis, Kathleen, 498
Lippmann, Steven B, MD, 233, 526

M

McCormick, Catherine C, LPN, 278
McMasters, Kelly M, MD, PhD, 222
Mejia, Ernesto, MD, 144
Morfesis, F Andrew, MD, 16

N

Nachbauer, Craig, MD, 314
Nash, Kenneth, MD, 233

P

Puruckherr, Michael, MD, 144

R

Ramirez, Julio, MD, 393, 500
Reynolds, Mark, MD, 59
Rogers, Anthony G, MD, 314
Roy, Thomas M, MD, 13, 59, 105, 144

S

Saha, Siby P, MD, 314
Schrodt, Jerome F, MD, 192
Sepehri, Shahram, 526
Singh, Surjeet D, MD, FRCP, 96, 432

T

Taber, Scott W, MD, 387
Tolentino, Arthur, MD, 393, 500

W

Woodring, John H, MD, 490

SPECIAL ARTICLES

Carpal Tunnel Syndrome — Effects of Litigation on Utilization of Health Care and Physician Workload, 287
Cox — Reflections on 35 Eventful Years as KMA's Leader, Robert G, 482
Fatalities in Kentucky — 1994, Occupational, 395
Generalists for Kentucky, Developing, 439
Genetic Disorders, Birth Defects and Syndromes in Central and Eastern Kentucky, The Prevalence of, 237
Medical Students Choice of Academic Medicine as a Career, Factors Influencing, 186
Mitchell, MD, KMA President 1996-97, Profile — William H, 452
Noncompetition Agreements in Kentucky Health Care, 154
Personal Profile, A, 487
Practice Location in Kentucky, Geographic Origin and Its Impact on, 446
Seat Belt Use in Kentucky — A Comparison of Five Measures, 110
Trauma System: Classification of Levels of Care Available to Injured Patients, Development of a Statewide, 63

SPECIAL ARTICLES AUTHORS

Blue, Amy V, PhD, 439
Cadle, Ronald G, MS, 237
Calhoun, R, MPH, 63
Dawson, Sara K, MA, 110
Dawson, Tasha, 237
Dolson, Scott W, 154
Donnelly, Michael B, PhD, 186, 439
Elam, Carol L, EdD, 446
Hall, Bryan D, MD, 237
Harrell-Parr, Peggy, PhD, 439
Jarecky, Roy K, EdD, 186, 439
Johnson, Mitzi MS, PhD, 446
Kasdan, Morton L, MD, FACS, 287
Lewis, Kathleen, BA, 287
McKnight, M, MD, 63

McKnight, Robert H, MPH, ScD, 110
Melhorn, J Mark, MD, 287
Moon-Hampton, Elyn, MA, 395
Murphy-Spencer, Amy, EdS, 186, 439
Nypaver, M, MD, 63
Parr, Peggy, PhD, 186
Pollack, Susan H, MD, 395
Rosenbaum, Marcy E, PhD, 446
Rubeck, Robert F, PhD, 186, 439
Scheerer, Amy, BS, 395
Schwartz, Richard W, MD, 186
Spurlock, Carl, PhD, 395
Stallings, Shawn P, MD, 287
Stapczynski, JS, MD, 63
Struttman, Tim W, MSPH, 395
Svenson, JE, MD, 63
Tharp, Sue, 452, 482, 487
Vender, Michael I, MD, 287

SPECIAL FEATURES

Delegate Roll Call, 546
Digest of Proceedings, 1996 House of Delegates, 549
Index to Proceedings & Reports, 550
Index to *Journal* Volume 94 — 1996, 606
KMA 1996-97 Committees, 601
KMA Organization Chart, 603
KMA Reference Committees, 552

ASSOCIATION NEWS

A

AMA's New "EVP," 251
Annual Meeting Preliminary Program, 323
Awards Nominations Form, 255

B

Board Meeting, Spring KMA, 247
Board of Trustees — December Meeting, KMA, 74
Board of Trustees Officer Profiles, New, 118
Board of Trustees Special Called Meetings, KMA, 164

C

CATO Society Meeting, Kentucky Statewide, 31
Cox, KMA's CEO, Honored With KHA Award of Excellence, Robert G, 296

D

Deceased Physicians, In Memoriam, 525

E

Exhibit Guide, KMA Annual Meeting, 354
Exhibits, Application for Annual Meeting Scientific, 244

G

Goodin Elected to AMA Council on CME, 27

H

Headquarters Office Moves to New Site in October, KMA, 408

K

KMA Annual Meeting, "Derby City" Hosts 1996, 267

L

Legislative Session in Summary, 1996, 179

M

Monitoring Medicine, 7, 47, 93, 135, 179, 219, 263, 309, 383, 429, 477

N

News, 32, 76, 120, 164, 207, 248, 297, 409, 464, 508

P

Peters, MD, Nominated KMA President-Elect, C Kenneth, 363
Physician Recognition Awards, 506
Practice Management Seminars, 1996 KMA, 79

S

Special Called Session — KMA House of Delegates, 135
Digest of Proceedings, 138
Roll Call, 140

V

Varga, MD, JCMS President, Daniel W, 409
VonderHaar, MD, Named Citizen Doctor of the Year, William P, 295

EDITORIALS

Autonomy, 23
Basics, Back to, 203
Bells Are Ringing, The, 402
Bright Side, The, 291
Civility: The Coarsening of America, The Decline of, 457
Kungsholm, The, 115
Mentors, 319
Pool, Everybody Out of the, 529
Patient's Last Advocate, The, 161
Physical Abuse is License for Societal Abuse, When a History of, 71
Refrigerator, Not Quite Like Buying a, 243
Tunnel Vision, THINK — About, 503
Word, What's in a, 403

EDITORIALS AUTHORS

Burns, Carolyn D, MD, 203, 503
Heyburn, Martha K, MD, 71
Mann, Wallace V, Jr, DMD, 403
Miller, Milton F, MD, 243, 529
Overstreet, A Evan, MD, 115, 402
Smith, Stephen Z, MD, 291
Varga, Daniel W, MD, 23, 319
Stulc, Jaroslave P, MD, 161, 457

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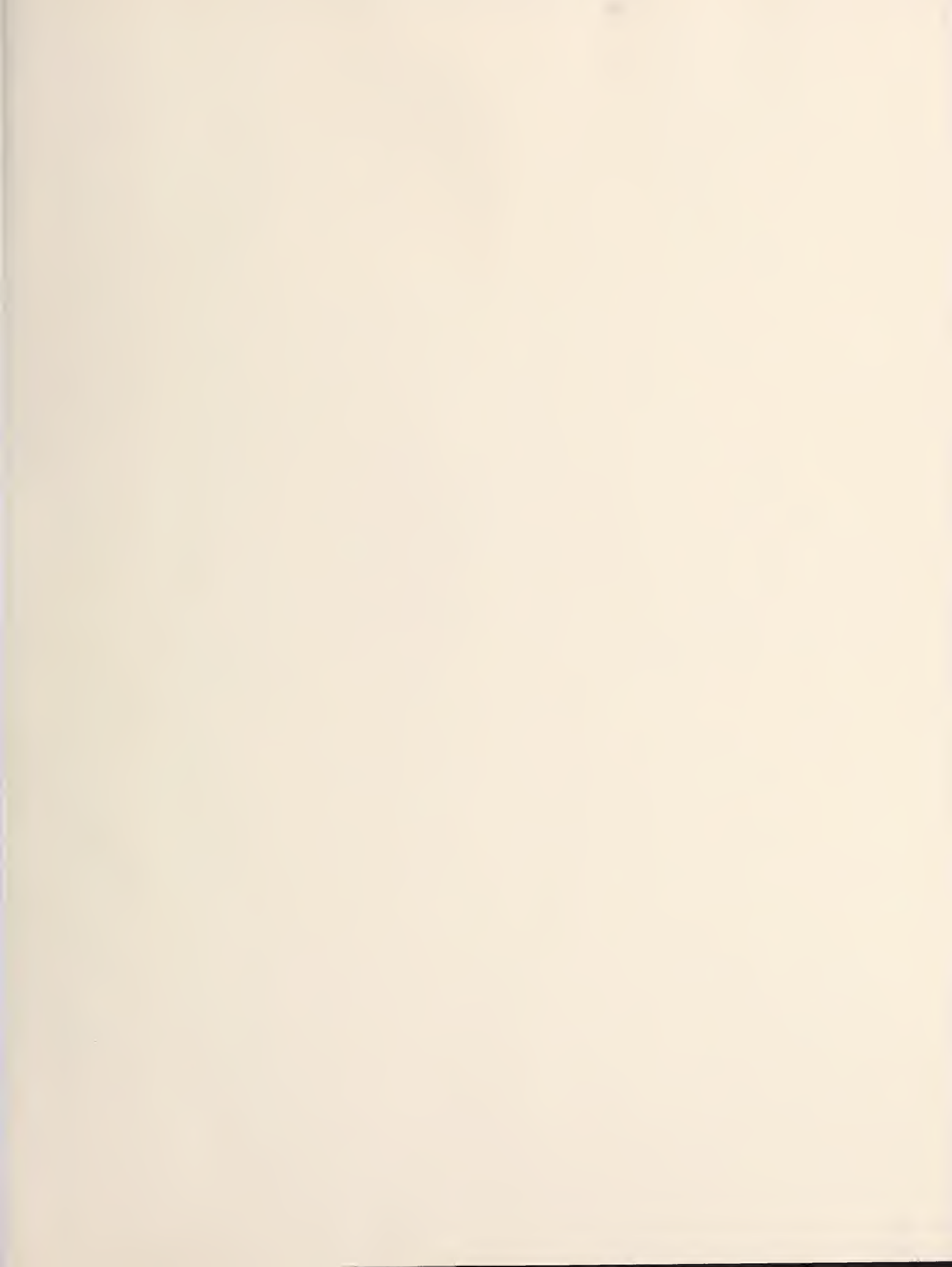
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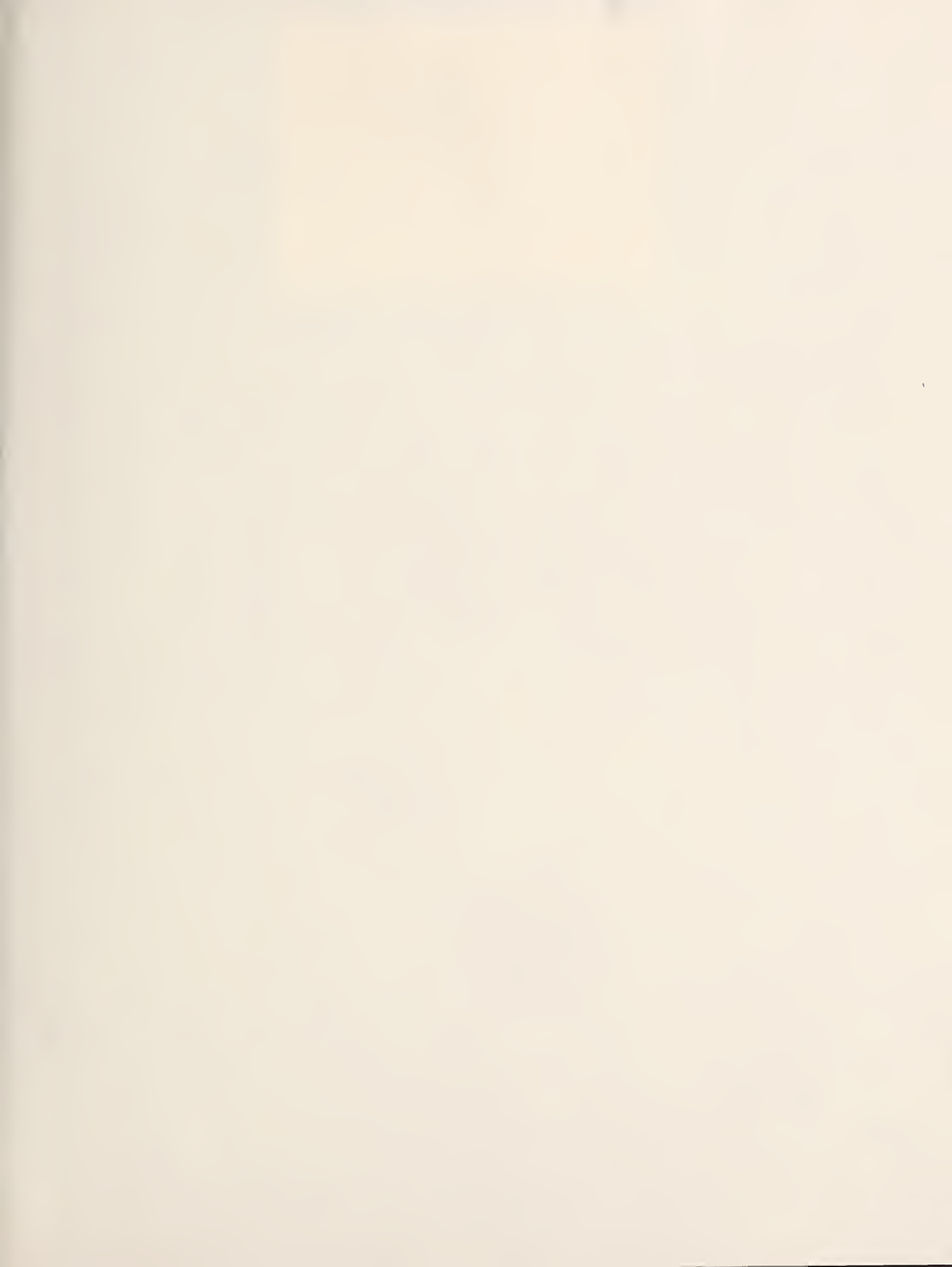


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